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Michigan Medicine

Medicaid cost control program for 1977

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MSMS goals for 1977 legislation

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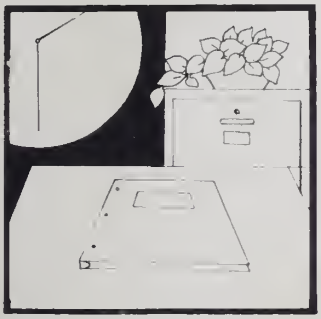

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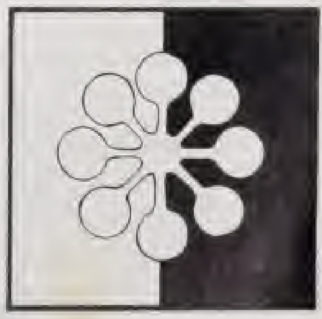
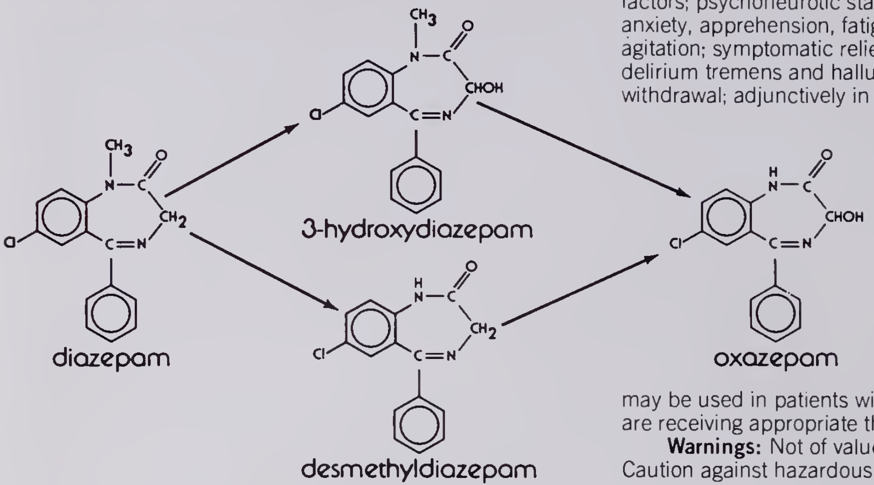


Special article:
Length of stay varies by weekend, weekday admissions

A pharmacokinetic character all its own



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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about contemporary issues and actions of the Michigan State Medical Society, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

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In the next issue . .

The CAT Scanner controversy.

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When **impotence** due to androgenic deficiency is driving them apart

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New Double-Blind Study ANDROID-25 *vs.* Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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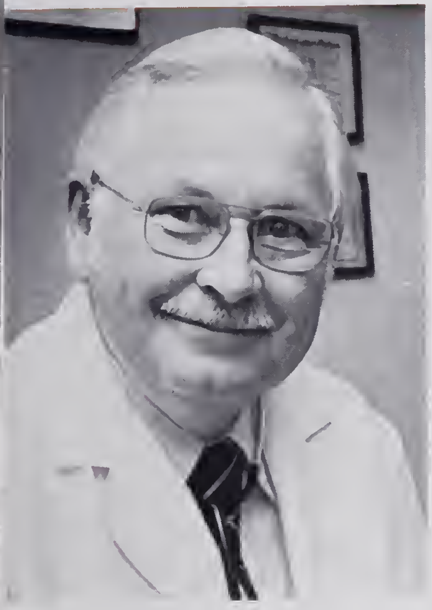


Robert M. Leitch, MD
MSMS President

Physicians needed now to serve with HSAs

A small group of Michigan physicians is carrying a heavy load for the rest of us.

Eight doctors on the Statewide Health Coordinating Council and 26 who are members of area Health Systems Agency boards are in on the action of implementing the National Health Planning and Resources Development Act of 1974 (PL 93-641).

It is time the rest of us joined them in gaining access to the decision-making process in this vast health planning thrust that will certainly reach all of our lives and our medical practices. Other health care organizations have insured their representation.

The HSAs are well on their way to shaping health care delivery in the nation and Michigan, and there is no reason for delay in participating. As the AMA notes in a recent Health Planning Bulletin, "The health planning process by its very nature is political. To achieve the aims of the federation — assuring that health planning is responsive to the needs of patients and the medical profession — societies must become politically active and involved in all levels of the planning structure."

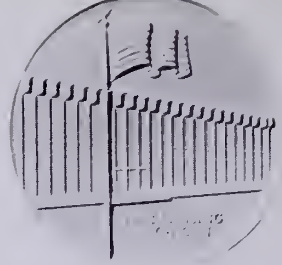
Because of the far-reaching impact of the planning law, MSMS is carefully monitoring its implementation in Michigan. In November the MSMS Committee on Federal Legislation and Related Matters invited all the physicians serving on HSA boards and on the SHCC to a special meeting to discuss current developments and potential problems in implementing the law. Robert E. Rice, MD, chairman of the committee, committed MSMS assistance to the physicians involved in health planning to insure communication and coordination among the HSA/SHCC physicians, component medical societies and MSMS.

It is imperative that physicians be aware of the impact this law will have for the future.

And while it is true that the law places restrictions on the number of physicians (providers) who can serve on HSA boards (a majority must be consumers), there is ample opportunity for physicians to play significant roles in the health planning process.

In addition, the AMA cautions, "due to the extreme complexity of PL 93-641, the law is conducive to local interpretations. Medical societies have access to a wide variety of medical expertise, and should draw upon individuals with expertise for interpretations. The interpretation most likely to prevail will be from those individuals having greatest credibility."

Let us therefore continue to monitor and where possible, become involved, in the decision-making process of health planning, and not allow it to fall by default to laymen and HSA staff members.



How you benefit as an MSMS member

—with an active communication program with news media.

MSMS takes the positive approach in its dealings for physicians with news media.

"We have taken time to develop good rapport with TV, radio and news people," says Mert Scholten, MSMS communications assistant for news media.

Reporters call MSMS almost daily and MSMS provides answers to questions and access to physicians who can act as spokesmen for the profession. MSMS sends news releases to 40 Michigan daily and weekly newspapers and to radio and TV stations. Mr. Scholten also sends items of interest to the reporters and makes feature story suggestions.

The MSMS news release policy calls for notices to be sent to the media only "when we really have something important to say." With that policy, newspapers, radio and TV stations pay attention when a release arrives.

Mr. Scholten arranges interviews and meetings for the media with MSMS leaders. Many of these interviews take place at the time of MSMS House of Delegates' Annual Sessions and of MSMS Scientific Meetings.

MSMS contacts new medical reporters for key papers and stations to offer help in gathering information. MSMS also provides statements of MSMS viewpoints to clarify issues. A recent letter from MSMS President Robert M. Leitch, MD, describing the MSMS stand on Medicaid was carried in 15 Michigan newspapers, including the Detroit Sunday supplements.

MSMS also is active in the production of three television programs around the state in which viewers ask questions directly of physician panelists.

Plans are underway to enhance MSMS media relations with workshops for physicians to help them understand the media better. In addition a new physician panel of experts on medical questions is being formed.

The panel first was proposed by Kalamazoo pediatrician and filmmaker Frederick Margolis, MD, in a *Michigan Medicine* article. The list of panelists would be available at MSMS headquarters for any reporters who wanted the right perspective on claims of treatments, drugs, cure rates and other such clinical subjects.

"Physicians in the past have asked for more favorable articles and programs," comments Mr. Scholten, "But you don't just order favorable stories. You work at them."

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Malpractice and CME targets of MSMS legislative goals

By Thomas Berglund, MD, Chairman
MSMS Committee on State Legislation and Regulation

A statutory definition of medical malpractice and an amendment to the continuing medical education law to require 150 hours of CME in three years, are chief goals of the Michigan State Medical Society as it heads into the 1977 session of the Legislature.

Drafted by the MSMS Committee on State Legislation and Regulations, an eight-point legislative program also aims to permit annuity-type and reparative judgments in malpractice cases, sharpen the Statute of Limitations to cover cases involving children, define expert witness qualifications, and amend the Brown-McNeely enabling statute to assure continuance until it is no longer needed.

MSMS has been in contact with legislators to assure introduction of the needed legislation.

The MSMS proposals include:

1 — **An act to define malpractice and require proof by the plaintiff.**

The MSMS-proposed definition would require that the plaintiff prove that he did not receive the recognized standard of acceptable care in the community and in the specialty practiced; that the defendant failed to act with ordinary and reasonable care in accordance with such community standards; and that the defendant failed to utilize timely, appropriate procedures to correct a medical accident or mistake which he knew or should have known occurred while the patient was under his direct supervision.

2 — **An act to define qualifications of an expert witness.**

The MSMS-proposed definition of an expert witness is a physician licensed to practice in Michigan or contiguous states, licensed and practicing at the time of the alleged malpractice, and practicing in a community of approximate size and medical characteristics.

3 — **An act to recognize collateral source income from an injury.**

The MSMS proposal would permit defendants to enter into the trial record any recovery due to the injury from sources other than the defendant.

4 — **An act to limit lack of informed consent as a cause of medical malpractice action.**

The MSMS proposes that it shall be a defense against an alleged failure to obtain informed consent if:

a — The risk not disclosed is too commonly known to warrant disclosure;

b — The patient assured the practitioner he would undergo the treatment regardless of risk, or that he did not want to be informed of the risks;

c — Consent by or on behalf of the patient was not reasonably possible;

d — The medical practitioner used reasonable discretion because he believed disclosure of risk could adversely and substantially affect the patient's condition.

5 — **An act to vary types of malpractice awards.**

The MSMS proposes that the same kind of variable awards available to arbitration panels should be available to litigants. These would include money damages, provision for rehabilitation, reparative procedures, loss of income, annuities or other equitable settlements.

6 — **An act to further tighten the Statute of Limitations.**

Several states have enacted statutes providing for tolling of the statute of limitations at an age less than age 18. MSMS is studying these statutes to determine its wisest course in statute of limitations improvement.

7 — **An act to require 150 hours of continuing medical education in three year cycles.**

MSMS proposes that the one-year 50-hour requirement enacted in 1975 fails to recognize that most physicians who belong to specialty societies have three-year CME requirements. MSMS will propose that such requirements supercede the present law.

8 — **An act to continue the Brown-McNeely fund.**

MSMS led the proposal two years ago to put a termination date on the state's medical malpractice fund, arguing that the state should be in the insurance business no longer than is necessary. MSMS will propose an extension of Brown-McNeely beyond July 1, 1977, but with language to assure the fund does not reach permanent status.

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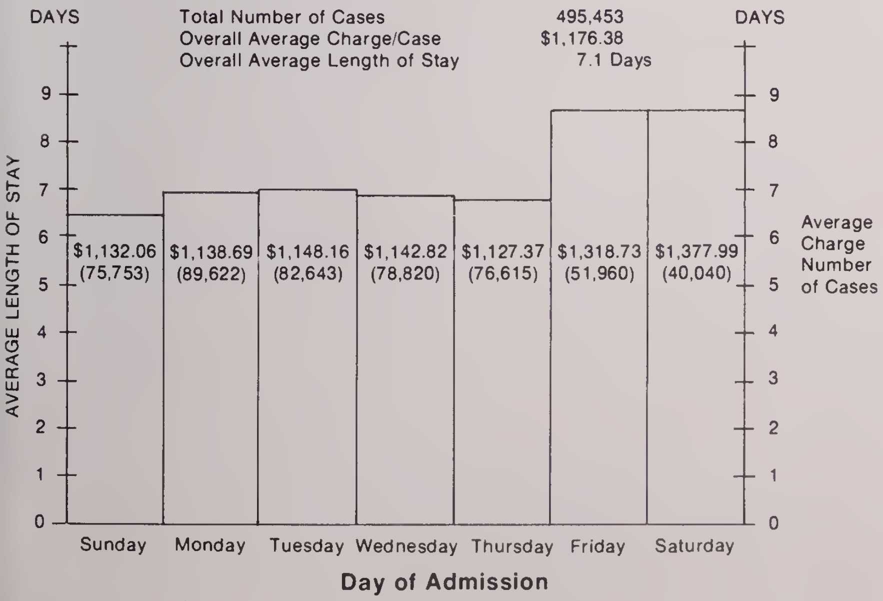
Blues' study shows weekend admissions result in longer length of stay

This paper is prepared by the Corporate Research Administrative Division, Blue Cross and Blue Shield of Michigan.

In an analysis of length of hospital stay by day of admissions, 459,453 hospital cases admitted in 1975 under Blue Cross and Blue Shield of Michigan's (BCBSM) Comprehensive Hospital Coverage were analyzed (**Figure 1**). Some 230 community hospitals located in Michigan and participating with BCBSM are represented in the study.

Figure 1 shows a dramatic difference in average length of stay for patients admitted on Friday and Saturday in comparison to patients admitted Sunday through Thursday. For example, Friday and Saturday admissions average 8.5 days of hospital stay while the average for Sunday-through-Thursday admissions is 6.8 days. The difference between Friday and Saturday's admissions is 1.7 average days of hospital stay. The difference is reflected in average-per-case-charges of $1,318.73 for Friday and $1,377.99 for Saturday admissions. The Sunday-through-Thursday admissions average-per-case-charge is $1,138.03. The difference between the Sunday-through-Thursday average-per-case-charge and the Friday average-per-case-charge is $180.70 which for 51,960 Friday admissions, amounts to $9,389,172. The difference in the Sunday-through-Thursday and the Saturday average-per-case-charges is $239.96. This difference totals to $9,607,998.00 for the Saturday admissions. These results are of both practical significance and are also statistically significant.

Figure 1. Length of Stay by day of Admission*
Blue Cross and Blue Shield of Michigan Admissions in 1975



To examine whether the type of diagnostic case influenced day of admission and subsequent length of hospital stay, two diagnoses requiring immediate hospital care were compared with two diagnostic categories not necessarily requiring immediate attention. **Table 1** shows that patients with diagnosis 650 — Normal Obstetrical Delivery, and patients with diagnosis 410 — Acute Myocardial Infarction had relatively uniform lengths of hospital stay irrespective of day of admission, while patients with diagnosis 455 — Hemorrhoids and patients with diagnosis 401 — Essential Benign Hypertension, showed the increased Friday and Saturday length-of-stay syndrome.

One may argue that the study did not incorporate sufficient controls for patient mix; that is to say, age and sex of patient, diagnosis, hospital and other factors related to day of admission of hospitalized patients and their length of stay.

But the sheer number of patients and hospitals reflected in this annual analysis suggests that many patients

TABLE 1

Length of Stay by Day of Admission and Diagnoses*

		Dx650	Dx455	Dx410	Dx401
	All	Normal Delivery	Hemorrhoids	Acute Myocardial Infarction	Essential Benign Hypertension
Sunday	6.5	4.4	6.5	14.9	8.0
Monday	7.0	4.4	6.7	13.7	8.0
Tuesday	7.0	4.4	6.5	13.9	8.7
Wednesday	6.9	4.4	6.4	14.8	8.5
Thursday	6.8	4.4	6.5	14.1	8.6
Friday	8.5	4.5	7.8	14.6	9.8
Saturday	8.5	4.5	10.0	14.9	9.2
Total	7.1	4.4	6.7	14.4	8.7

*Corporate Research, Blue Cross and Blue Shield of Michigan, 1975 Hospital Data.

hospitalized on Friday and Saturday receive only custodial care on Friday and Saturday and not medical care on these days, and that this mode of treatment is a way of life for many Michigan hospitals. Just which hospitals and patients and under what conditions follow this method of hospitalization are the subject of studies presently in progress.

In view of the fact that a hospital has to remain open 24 hours a day, seven days a week, having paying patients on Friday and Saturday is a way of helping to defray expenses. However, there may be more efficient ways to defray expenses than admitting patients on Friday and Saturday and beginning medical care on Sunday or Monday. Medically treating the patient on the day of admission and thereafter until discharge is an obvious way. Scheduling a skeleton staff on Friday and Saturday is another option. There are, of course, other alternatives. How this can be accomplished can best be handled by the medical staff and hospital administrator.

The important conclusion though, is that escalating health care costs are a matter of national concern and positive action for this seeming incongruity in length of stay for Friday and Saturday hospital admissions is a matter of prime importance.

Blue Cross and Blue Shield of Michigan is actively engaged in searching out where cost reduction can be made and it would appear that Friday and Saturday admission is a place where reductions can be made. To that extent, programs are under study to insure that BCBSM reimbursement is for inpatient days during which active treatment is occurring.

PM Seminars in February for new physicians

Physicians planning to enter practice soon are invited to participate in two practice management workshops jointly planned by MSMS and the AMA on Feb. 7-8 at the Michigan Inn, Southfield, and on Feb. 9-10 at MSMS headquarters, East Lansing.

The seminars will take up personnel problems, patient flow techniques, physical aspects of the medical office, paperwork — both clinical and financial, the practice setting and legal problems. The socioeconomic aspects of medical practice will be discussed at luncheon.

The seminars will be presented by professional management consultants from California. Further information is available from the Bureau of Economics, MSMS headquarters, 120 W. Saginaw St., East Lansing, 48823.

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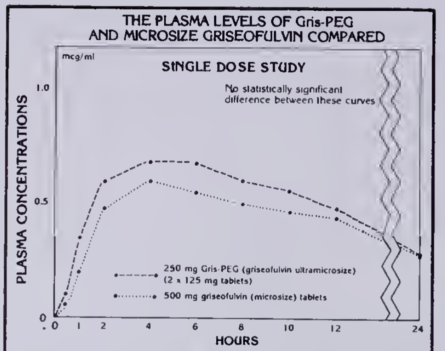
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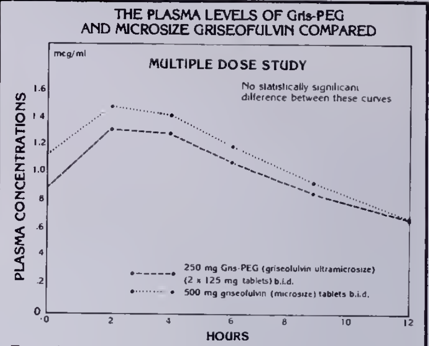
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Based on a double-blind multiple dose steady state crossover bioavailability study conducted in 17 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels obtained on days 9, 11 and 13. There is no significant difference between times to peak, peak plasma levels, and areas under the curve. Gas chromatographic assay.

DESCRIPTION

Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION

Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum*, *Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsized griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy.

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS

Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections.

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis; ringworm of the nails)

when caused by one or more of the following genera of fungi:

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleini
Microsporum audouini
Microsporum canis
Microsporum gypseum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is not effective in the following:

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS

This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS

Prophylactic Usage: Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5-2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy: The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress.

Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS

Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists; however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS

When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSAGE AND ADMINISTRATION

Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6 weeks; *tinea corporis*, 2 to 4 weeks; *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months; toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsized), USP (see ACTION Human Pharmacology).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis, the following dosage schedule for children is suggested:

Children weighing over 25 kilograms (approximately 50 pounds)—125 mg to 250 mg daily.

Children weighing 15-25 kilograms (approximately 30-50 pounds)—62.5 mg to 125 mg daily.

Children 2 years of age and younger—dosage has not been established.

Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED

Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin (microsize) tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsized griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsized griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.

Dorsey
LABORATORIES
Division of Sandoz, Inc. • LINCOLN, NEBRASKA 68501

MSMS Liaison Committee Receives State Plan to Cut Medicaid Costs

By David Siegel, MD
Lansing

A series of comprehensive Medicaid cost containment measures directly affecting physicians was approved by the Michigan executive offices as this issue was going to press. A report on the action and the bulk of the measures are printed here for every MSMS members' study.

An action plan to reduce Medicaid expenditures for fiscal year 1976-77 has been approved by the Governor's Cost Containment Steering Committee.

All providers were invited by the Department of Social Services to offer cost savings recommendations. MSMS participated in a series of meetings in early November to help draft the proposals. John T. Dempsey, PhD, DSS Director, responded to providers' assistance with a letter to MSMS President Robert M. Leitch, MD, stating:

"Thank you for your association's assistance in the development of recommendations to reduce costs and eliminate the shortage of funds for the operation of the Medical Assistance Program . . . I strongly feel that we must maintain the mutual cooperation which was developed in this joint effort to combat the impending fiscal crisis faced by the state due to the increasing costs of the Medicaid program."

In November, the DSS had predicted a $54 million deficit. Based on additional information now available for October, November, and early December, the Department estimates that Medicaid costs for the current fiscal year will total $844 million rather than the previously projected $866 million. DSS Director Dempsey cautions that "any sudden increase in the caseload could, of course, force actual costs upward."

As a result of the cost containment recommendations, two important items impact practicing physicians: The eleven percent reduction of physicians' fees was rescinded retroactive to Oct. 1, 1976; and, the four percent reduction of fees has not yet taken place. The four percent reduction is scheduled for implementation on Feb. 1, 1977. As an incentive to encourage ambulatory care, rather than more costly emergency room care, etc., the four percent reduction *will not* apply to office visits, home visits, nursing home visits, and injections.

Proposed "short-range proposals," including expected implementation dates and cost savings, and "long-range proposals" are attached.

Short-range proposals

1. Implement pre-admission testing and apply limitation on Friday/Saturday admissions (i.e., not allow Medicaid admissions on Friday or Saturday except for emergency cases or in those hospitals which are fully staffed and fully operational over the weekend). *Effective Date: 2/1/77; Projected Savings: $1,600,000.*

2. Implement prepayment review of all hospital invoices for patients staying beyond the 75th percentile length of stay. *Effective Date: 2/1/77; Projected Savings: $2,900,000.*

3. Implement the identification of third party liability resources which our recipients have, monitor provider use of other resource information in their billings to us, and require quarterly submission of the other resources log and payments from hospitals. *Effective Date: 2/1/77; Projected Savings: $2,100,000.*

4. Eliminate the blood handling fee to coincide with the revised laboratory methodology (item 8 below). *Effective Date: 4/1/77; Projected Savings: $200,000.*

Doctor Siegel is chairman, MSMS Medicaid Liaison Committee.

Toward greater realism

The Medicaid cost containment package presented Dec. 16 to the MSMS Medicaid Liaison Committee is predicated, for physician services, on 1973 Medicare screens. From the Liaison Committee's meeting with Department of Social Services officials came agreement to begin renegotiating figures based on the most recent Medicare screens. While the dollar figures will not change, use of current Medicare screens will reflect more truly the actual differential between Medicaid payment levels and payments by other third party payors. MSMS has established use of "current Medicare screens" by the department as its highest Medicaid priority.

5. Implement (in cooperation with the Legislature) the requirement that nursing homes must be certified for both Title XIX and XVIII. *Effective Date: 2/1/77; Projected Savings: $3,900,000.*

6. Do not restore additional over-the-counter drug benefits. *Effective Date: 12/1/77; Projected Savings: $2,000,000.*

7. Implement a generic drug policy which would reimburse pharmacists the reasonable generic price of the top 24 generic drugs unless the prescription is written "dispense as written." We will appoint a committee composed of practitioners and pharmacists to assist us in implementing this. *Effective Date: 3/1/77; Projected Savings: $600,000.*

8. Develop and implement a revised laboratory reimbursement policy. A study is being done by DSS and MDPH with the cooperation of the laboratory industry and will result in new rates and revised reimbursement philosophy to encourage use of automated testing. *Effective Date: 4/1/77; Projected Savings: $1,200,000.*

9. Implement a frequency requirement for eye examinations consistent with other vision care and implement the revised vision codes and policy. *Effective Date: 2/1/77; Projected Savings: $2,300,000.*

10. Implement a 50¢ copayment for pharmaceutical services. *Effective Date: 2/1/77; Projected Savings: $3,200,000.*

11. Implement the Estimated Cost Reimbursement System (ECRS) which will step-wise implement the cost index and interim reimbursement approach for hospitals. *Effective Date: 3/1/77 for the first 40 hospitals; Projected Savings: $1,000,000 to $3,000,000.*

12. A. Implement a 4% reduction in fees to the following providers: Physicians (except home and office visits), dentists, podiatrists, chiropractors, vision, speech, hearing, methadone maintenance, community mental health services, medical supply firms (non-pharmaceutical), laboratories, and radiology.

B. NOTE: As an incentive to deter over-use of more costly services provided in an institutional setting, e.g., emergency room or inpatient services, the 4% reduction does *not* apply to the charges for home or office visits. *Effective Date: 2/1/77; Projected Savings: $6,300,000.*

13. Require all providers of services to ask for a second (picture) identification before providing services (except in emergencies). *Effective Date: 2/1/77; Projected Savings: N/A.*

14. Maintain rates for MCF/CCU at present level. Do not apply proposed 4% increase. *Effective Date: Immediate; Projected Savings: $1,000,000.*

Total Projected Savings:

$29.5 Million to
$31.5 Million

Long Range Proposals

(These proposals have been identified as long-range cost containment measures as they will require six months or longer to implement. They are listed in ascending order of the amount of research and legislative activity which would be required before they can be effectively implemented.)

Hospital and Therapy Appropriation Account

1. Use direct referral from the primary physician for physical therapy services thereby avoiding some costly consultation fees.

2. Set priorities for the physical therapy service now covered, then reduce coverages where appropriate.

3. Utilize physical therapy consultation services for surveillance and utilization review, including the use of physical therapists in hospital utilization review activities.

4. Require secondary concurrence on *seven* surgical procedures including tonsillectomies and inpatient gynecology surgery.

5. Remove some excess beds from the hospitals. This proposal put forth by the Michigan Hospital Association is being explored by state and association members as a long-range solution for cost containment.

6. Modify the hospital reimbursement formulas to assure that Medicaid pays the same rate for covered services regardless of the patient setting. For example: pay hospitals up to the maximum fee screens in effect for pharmaceuticals, laboratory tests, X-rays, rather than the current cost settlement amounts paid for these services. This proposal will require additional legislation before it can be effectively implemented.

7. Require a co-payment for emergency room services from all recipients to curb excess utilization. This proposal will require a change in the current federal regulations.

Physician Appropriation Account

8. Establish a new reimbursement policy for laboratory services provided by practitioners. Included in this would be a requirement for licensing and enrollment of practitioners (as laboratories) when laboratory volume exceeds a predetermined rate.

9. Reimburse qualified nurse practitioners and physician assistants who render care under Medicaid to patients outside of the acute care hospital setting.

10. Require a co-payment for physician visits. This proposal would require a change in the current federal regulations.

Nursing Home Services

11. Review nursing home legislation regarding the Patient Pay Trust

Fund requirement. Additional legislation would be needed.

12. Review divestment in the Medicaid program. A legal base is needed to avoid divestment by a client for the purpose of securing nursing home payments by Medicaid.

13. Provide an improved assessment system, perhaps through a program of patient assessment centers to more properly and more rapidly direct patients into and out of hospitals and also into less expensive settings such as homes for the aged, supervised residential care, or *their own homes.*

14. Conduct an independent research study of criteria used to determine bed needs.

15. Establish a prospective reimbursement proposal for institutional care providers.

Transportation Appropriation Account

16. Conduct a research study to determine when appropriate ambucab or alternative modes of transportation should be used instead of ambulances.

17. Enroll, categorize, and reimburse ambulance companies on the basis of the type of service, and the type of company.

Pharmaceutical Appropriation Account

18. Establish pharmaceutical consultants who are not the facility's pharmacy provider to serve on the review body of long term care institutions.

19. Establish Medicaid policy which requires the passing on of discounts and such savings that are given to any other segment of the general public.

20. Establish a limit on the number of prescriptions, both legend and non-legend, that a recipient may receive per month.

21. Require all laboratories to bill Medicaid at the lowest rate.

22. Establish a limit (dollar maximum) on the amount of laboratory services provided for a recipient and require prior authorization for services in excess of the limit.

Auxiliary Medical Services Appropriation Account

23. Develop a system of mass purchase of frames and lenses from optical laboratories.

24. Establish a maximum reimbursement of $100 (or $50) for low vision aids.

25. Exclude visual training (other than orthoptic or pleoptic) from coverage.

General Proposals

(These proposals will result in cost savings in multiple appropriation accounts. Their impact is not directed at any one program area. Therefore, they are considered to be overall policy considerations for the program.)

26. Initiate an educational campaign directed to all providers and recipients calling attention to the fiscal problem facing Michigan through the Medicaid program. They should be urged to provide only essential services, to discourage unnecessary office calls, to discharge institutionalized patients at the earliest possible date.

27. Implement a study to determine the frequency with which MA-ID cards are misrepresented and misutilized as they are presented to providers for services rendered. This study would provide basic research information for future policy and procedure considerations intended to curb recipient program abuse.

28. Use utilization and surveillance data to direct further tightening of front end edits to the system. This expanded S/UR system will also allow the program to identify Medicaid patient and provider abuse and/or overutilization.

29. Forms modification: A number of proposals to make Medicaid forms more efficient and usable were proposed.

30. Change state laws to ease the prosecution of providers and recipients who intentionally misutilize the program.

31. Pursue a policy which will encourage the use of tape-to-tape billings to reduce data processing and administrative costs.

32. Review of Medicaid care levels by medical social worker. Several individual ideas encompassed the prevailing thought that patient utilization of services should be coordinated and limited by a central point in the delivery system. The staff interpretation of these various ideas fosters the concept of a medical social worker becoming the coordinator of the medical services needed and received by the eligible population.

33. Establish a special category for the temporarily unemployed. The temporarily unemployed should be required to wait six months before receiving benefits paid for by the Medicaid Program, except for emergencies.

34. All providers should be required to provide peer review on the request of DSS (as MSMS has provided), but remain free from liability.

35. Establish a liaison group of concerned providers and state officials to review state and federal regulations and to negotiate with the federal government in order to implement Michigan cost containment proposals which conflict with current federal law and/or regulations.

36. Implement automated Prior Authorization System.

The MSMS Medicaid Liaison Committee has reviewed the proposals at length, and will monitor the development of each proposal as the department attempts to implement them.

First Quarter

Your 1977 tax calendar

"In this world nothing is certain but death and taxes."
– Benjamin Franklin

Ben Franklin could not have conceived of the maze of tax forms that a businessperson must fill out these days. Below is an abbreviated calendar that lists the *major* forms that must be filed depending on whether you are a corporation, a partnership, or a solo physician. Also included are the forms which employers must file.

Please note that this list does not include some forms which may apply to some specific situations. It is advisable to contact the IRS or an accountant to be certain that you are filing all that applies to your practice and tax situation.

January 15

INDIVIDUALS must pay the balance due on their 1976 estimated income tax.

January 25

EMPLOYERS must file Michigan unemployment taxes contribution report (MESC 1020).

January 31

INDIVIDUALS should file Form 1040 for 1976 and pay the tax due if the balance due on the 1976 estimated income tax was not paid by January 15.

EMPLOYERS must give every employee Form W-2 and Form W-2P indicating income and social security information.

EMPLOYERS must file Form 508 and must deposit Federal unemployment tax liability with a depositary. No deposit is necessary if liability for the quarter is not more than $100. If timely deposits were made, see February 10.

EMPLOYERS must file Form 941 for income tax withheld and social security taxes for the fourth quarter of 1976 and pay taxes due. If timely deposits were made, see February 10.

EMPLOYERS who pay Federal unemployment tax must file an annual return for 1976. Use Form 940. If timely deposits were made in full payment of the tax, see February 10.

ALL PRACTICES must make their estimated payments on the Michigan Single Business Tax.

INDIVIDUALS must make estimated payments on City Income Tax (where applicable).

February 10

EMPLOYERS who have made timely deposits in full payment of all income taxes withheld and social security taxes due for the fourth quarter of 1976, file fourth quarter return (Form 941).

EMPLOYERS who made timely deposits in full payment of the Federal unemployment tax must fill an annual return for 1976 (Form 940).

February 28

ALL PRACTICES must fill annual information returns covering reportable payments of $10 or more made in 1976 of certain dividends and interest. This also includes payments of rents, annuities, pensions, and other fixed or determinable income totaling $600 or more. Use Form 1096 to summarize along with the appropriate Form 1099.

EMPLOYERS who have issued Forms W-2, W-2P, and 1099R must file Form W-3 (Transmittal of Income and Tax Statements). Copy A of each Form W-2, W-2P, and 1099R must accompany Form W-3.

March 15

CORPORATIONS must file a 1976 income tax return (Form 1120), and pay at least 50% of the balance of the tax still due to a depositary (Form 503).

April 15

INDIVIDUALS must file an income tax return (Form 1040) for 1976. The tax due must be paid in full with the return. If applicable, Schedule C must be filed with this return, and Schedule SE must be completed so that you receive proper social security credit for self-employment income.

INDIVIDUALS who have an individual retirement savings program must file Form 5329 as an attachment to Form 1040.

INDIVIDUALS must file their estimated income tax (including self-employment tax) for 1977 and pay at least 25% of it. Use Form 1040-ES.

PARTNERSHIPS must file an income tax return for 1976 (Form 1065).

CORPORATIONS must pay 25% of their 1977 estimated income tax to a depositary. Use Form 503.

INDIVIDUALS must pay Michigan State Income Tax (Form MI-1040).

PARTNERSHIPS must file their Michigan State Income Tax (Form MI-1065).

(This calendar to be continued in later issues.)

- **In addition to the above, EMPLOYERS must add the employer and employee social security taxes and the income tax withheld for each month. The total liability will determine whether deposits are necessary and, if so, how often they must be made. This requires use of Form 501. Because this varies from employer to employer depending on the size of the payroll, it is not possible to chart this as part of the calendar. Be sure to check with the IRS or an accountant to be sure that you are making your deposits at the correct time.**

This article is prepared by the MSMS Bureau of Economics.

20/150 H

20/100 EAR

20/70 ING IS

20/50 AS PRECIOUS

20/40 AS SIGHT HAV

20/30 YOU HAD YOUR HEA

20/20 TESTED LATELY A SI

20/15 COMFORTABLE HEARING

20/10 INVESTMENT OF A FEW MIN

Hearing losses are among the most consistently neglected health problems. Many people with them won't even admit it to themselves, let alone others. A little encouragement may start them thinking about themselves more realistically.

That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

Professional Relations Division, Beltone Electronics Corporation
4201 West Victoria Street, Chicago, Illinois 60646, an American company

Beltone
WHEN A HEARING AID WILL HELP

WHEN
BURNING PAIN
COMPLICATES
ACUTE
CYSTITIS*

TURN IT OFF WITH

AZO GANTANOL®

Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.

FOR THE PAIN

- Quickly relieves painful symptoms such as burning and pain associated with urgency and frequency.
- Recommended antibacterial therapy: up to 3 days with Azo Gantanol, then 11 days with Gantanol (sulfamethoxazole).

FOR THE PATHOGENS

- Effectively controls susceptible pathogens such as *E. coli, Klebsiella-Aerobacter, Staph. aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*.

*nonobstructed; due to susceptible organisms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris)* in the absence of obstructive uropathy or foreign bodies.

Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

How it looked: The 1976 MSMS Scientific Meeting

A total of 1,818 Michigan physicians filled the 48 CME courses presented Nov. 9-11 at the Hyatt Regency, Dearborn. Exhibits which grabbed doctors' interest included one on immediate interpretation of EKGs by telephone, as visited by M.S. Quadir, MD, Onekama, center, and Richard D. Nicholas, MD, Detroit, right.

Key persons in the planning and execution of the MSMS Scientific meeting were Robert F. Wilson, MD, Detroit, left, general meeting chairman, and John G. Wiegenstein, MD, Lansing, chairman, MSMS CME Programming Committee, which sponsored the three-day event.

The requirement that Michigan physicians earn 50 CME credits per year is a stiff one, and demands dedication to the goal.

The U-M Media Library, a self-study series of programs, was a popular method of CME.

Scores of physicians visited the special CME question and answer booth in the exhibit hall, which was manned by Mrs. Sherry Wellman of the MSMS staff and above, Bert Brennan, right, executive director, Michigan Medical Practice Board.

MSMS leaders joined their colleagues as students during the Scientific Meeting. Among them were Robert M. Leitch, MD, MSMS president, left, and Vernon V. Bass, MD, MSMS president-elect.

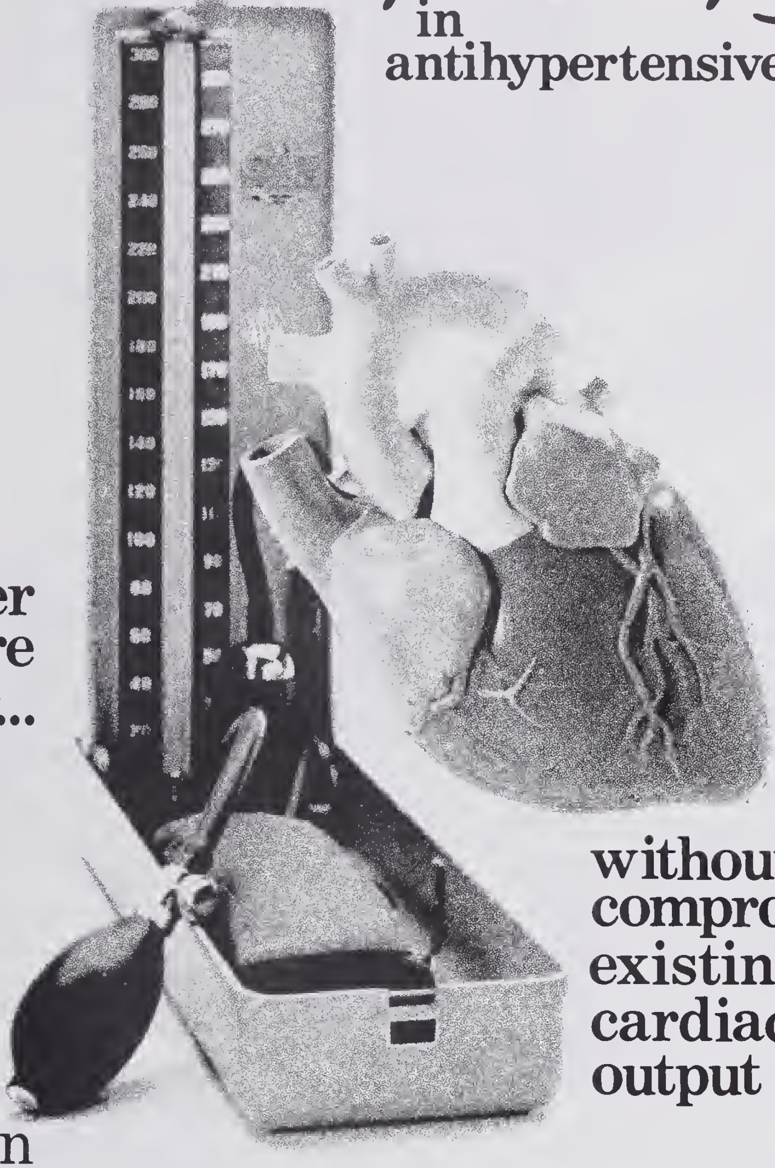
The news media interviewed several physicians during the meeting. Among them was John J. Coury, Jr., MD, Port Huron, right, AMA trustee.

Each physician attending the six Basic and Advanced Life Support Courses taught during the Scientific Meeting by Dan Anbe, MD, Detroit, left, had the opportunity to actually practice cardiopulmonary resuscitation.

(Continued on page 21)

A Dual Challenge

in
antihypertensive therapy



to lower
blood pressure
effectively...

without
compromising
existing
cardiac
output

in hypertension

TABLETS: 250 mg, 500 mg, and 125 mg

ALDOMET® (METHYLDOPA | MSD)

helps lower blood pressure effectively...
usually with no direct effect on
cardiac function–cardiac output
is usually maintained

ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyldopa therapy has been associated with liver disorders.
It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

For a brief summary of prescribing information, please see following page.

MSD
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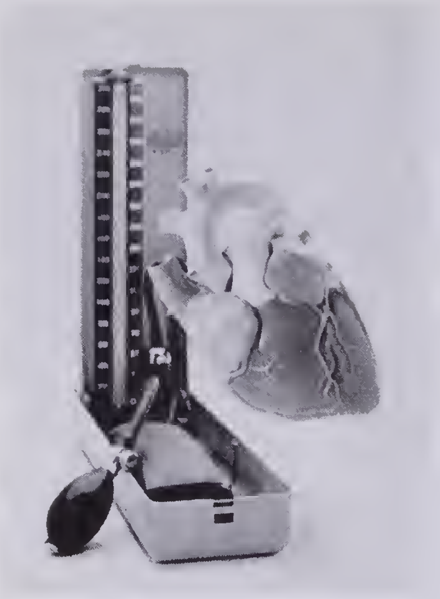

in hypertension

ALDOMET®

(METHYLDOPA|MSD)

helps lower
blood pressure
effectively...
usually with no
direct effect on
cardiac function–
cardiac output is
usually maintained

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites. Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486 J6AM07(707)

MSD MERCK SHARP & DOHME

There were 189 faculty members to present the 48 CME courses during the three-day MSMS meeting. And each one of them was welcomed to the meeting in the MSMS Faculty Lounge, where course directors could meet instructors and review notes for each course. Each course was aided by an MSMS staff assistant. Above, in those roles are Lawrence Hawkins, MD, Hastings, instructor; MSMS staff member John Richards; James R. Spindler, MD, Hastings, course director, and instructors Robert Borer, MD, Ann Arbor, and John Hartline, MD, Kalamazoo.

Among distinguished faculty were, from left, WSU School of Medicine Dean Robert Coye, MD; MSU Nutritionist Dena Cedarquist, PhD, and obstetrics/gynecology course director Joan Stryker, MD, Detroit.

Physicians entering each course were presented with course materials and evaluation sheets by MSMS staff members, among them Priya Shastri, above. The doctor is George Thosteson, MD, Detroit, author of the syndicated newspaper column.

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The Michigan Heart Association provided blood pressure tests as a special service during the Scientific Meeting.

1976 MSMS Scientific Meet breaks records

By Warren F. Tryloff MSMS Director

The recent 1976 MSMS Annual Scientific Meeting, Nov. 9-10-11 in Dearborn, was an entirely different project than all the former annual scientific meetings — and appears from all aspects to have been a really successful program to serve Michigan physicians.

Let me review some of the highlights, and then provide a short report about the project: (The MSMS Committee for Continuing Medical Education, which was responsible for the project, already has presented its observations and recommendations to the MSMS Council. A complete financial report has been made also.)

- More than 2,000 Michigan physicians participated in courses and other events at the three-day meeting at the Hyatt Regency Dearborn — the largest figure ever.
- A total of 1,818 physicians registered for one or more of the 48 Category I courses.
- A total of 203 physicians registered for specialty society activities.
- All course registrations totalled 4,908.
- A total of 11,168 hours of Category I Credit was awarded.
- 48 courses were developed by course directors, double the number of courses that the programming committee predicted in its report to the July meeting of the MSMS Council.
- 25 specialty societies cooperated to present courses or related activities, as did seven MSMS sections.
- A total of 186 Michigan and out-of-state physicians taught or directed the 48 courses. Only 25 were from other states.

In addition,

- Many hours were spent by John G. Wiegenstein, MD, Lansing, chairman of the new MSMS Committee for Continuing Medical Education Programming, which supervised this program.
- Many hours were spent by Robert F. Wilson, MD, Detroit, who served as program director for the 1976 meeting, developing good ideas for courses, advising and counseling course directors.
- Many hours were spent by Herbert A. Auer, manager of the MSMS Department of Communications and CME Programming, who coordinated the programming aspects of the meeting; and by Wayne E. Burmeister, manager of the MSMS Department of Member Services, who coordinated the physical arrangements and registration.
- Twenty-four MSMS staff members carried responsibilities prior to and/or during the Annual Scientific Meeting.

The major goal of the planners for our 1976 meeting was "to offer courses that were indeed planned programs, with sufficient scope and depth of subject to form an educational unit that was carefully planned, coordinated, administered and evaluated in terms of educational objectives."

The physicians who registered were encouraged to fill in a questionnaire about what attracted them to the meeting, when and where they would like future meetings, etc., and the tabulations provide some interesting information. (651 questionnaires were collected and tabulated.)

The doctors did not swarm to the 1976 Annual Scientific Meeting to get Category I credits, as many of us thought might be the case. Almost 65% of those who attended already had their 25 hours of credit. The doctors came because the courses covered dealt with vital subjects, by distinguished teachers and in a good setting.

COFFEE LOUNGE
ssociation of Assistants Michigan
an State Society

Coffee was provided for physicians touring the exhibits by members of the State of Michigan Branch, American Association of Medical Assistants.

MSMS gratefully acknowledges the hospitality provided by the State of Michigan Branch, American Association of Medical Assistants, for the many Michigan physicians attending the Scientific Meeting. Medical Assistants pouring coffee in the exhibits area were Washtenaw — Nelda Gasperson, general chairman; Kalamazoo — Phyllis Marquardt; Macomb — Marilyn Ruth, Ann Frattarelli, Barbara Baumgart, Margaret Gray, and Mary Ann Mack; Oakland — Audrie Chute, Carol Korponeke, Diane Lindeman, Liz Stabeck, and Dorothy Graves; Washtenaw — Rose Aronen and and Jessie Clark; Wayne — Pat Ralko; and Western Wayne — Juanita Artman, Sheila Basilisco, Margery Hosman, Ruth Sanecki, Barbara Verseput, Loni Stefanik, Sunday Ciemierek, Irene Nichol, Gayle Beauregard and Sharon Walk.

consider the effect on coexisting diabetes when you prescribe a vasodilator*

(POSTERIOR VIEW OF PANCREAS)

no interference in the management of the diabetic patient has been reported with

VASODILAN®

(ISOXSUPRINE HCl)

TABLETS, 20 mg.

the compatible vasodilator

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***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

Dosage and Administration: 10 to 20 mg. three or four times daily.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Adverse Reactions: On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

Supplied: Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

Heartbeat

By Mert Scholten
MSMS Communications Department

Irwin S. Finkelstein, MD, Bloomfield Hills psychiatrist, is new medical director of the Genesee County Community Mental Health Services. He was formerly director of psychiatric education and research at Clinton Valley Center.

* * *

Marilyn Heins, MD, and Jennifer Jacobs, MD, Wayne State University School of Medicine faculty, and two women from the Center for Urban Studies, published an article on the "Productivity of Women Physicians" in the Oct. 25, 1976 issue of the *Journal of the American Medical Association.* The four page article details the results of a study of Detroit-area female physicians to determine the scope and extent of their medical practice activity. An AMA news release highlighting the article has been widely used by a host of papers across the nation.

* * *

Rex Moe, MD, Kalamazoo obstetrician-gynecologist, was featured in a lengthy and delightful feature article in the November/December issue of *Encore,* Magazine of the Arts. Entitled "Every Delivery Was Special," the article relates the Kalamazoo native's life story and current retirement due to cataracts.

* * *

J. P. Papp, MD, Grand Rapids, authored "Endoscopic Electrocoagulation of Upper Gastrointestinal Hemorrhage" which appeared in the Nov. 1, 1976 issue of the *Journal of the American Medical Association* . . . In the same issue Doctors P. Kelly and J. A. Penner of Ann Arbor coauthored "Antihemophilic Factor Inhibitors."

* * *

Albert D. Ruedemann, Jr., MD, Detroit, was elected third vice-president of the 11,000-member American Academy of Ophthalmology and Otolaryngology at the recent annual meeting of the group in Las Vegas.

* * *

John W. Sigler, MD, and Yvan J. Silva, MD, Detroit, were among the guest faculty at the recent annual scientific meeting of the Indiana State Medical Association in Indianapolis. Doctor Sigler presented "Ankylosing Spondylitis and Rheumatoid Variants" while Doctor Silva spoke on "The Evolution of Medical Practice in the U.S.A., Tomorrow's Changes."

* * *

Frederick W. VanDuyne, MD, Flint, was recently re-elected president of the Michigan Medical Practice Board for a term ending Sept. 30, 1977. VanDuyne, a member of the board since the mid-1960s, previously served as vice-president of the board.

* * *

Michael A. Wainstock, MD, Detroit, published an article, "Ultrasonic Guided Gamma Probe for Intraocular Melanoma Detection" in *Nuclear Ophthalmology,* a new book printed by John Wiley and Sons. The article developed out of work at the U-M funded by a "Fight for Sight, Inc." grant.

Letters

"All material gratefully received . . ."

For a biography of Dr. Alton Ochsner of Ochsner Clinic, New Orleans, opinions, evaluations, anecdotes, reminiscences, photos are needed. Photos will be carefully handled and returned. All material gratefully received by

Ira Harkey, PhD
401 Metairie Road, 706
Metairie, Louisiana 70005

"The meeting was outstanding . . ."

Thank you for allowing four graduate students in health education from Central Michigan University to attend your 1976 MSMS Annual Scientific Meeting.

The meeting was outstanding from two standpoints — the courses that were offered and the exhibit area.

I have gained a tremendous amount of knowledge and insight from this experience.

Beverly Foyt
CMU graduate student

"Thank you for forwarding draft . . ."

Thank you for forwarding to me the draft of the paper written by Miss Jean Pearson in regard to the MSMS (and others) hassle with BC-BS in Michigan. This is greatly appreciated.

I would like quotes on or reprints of this article. I think I would like to send it specifically to presidents and secretaries of our state chapters and then have a small supply of copies at hand.

William C. Stronach
Executive Director
American College of Radiology
Chicago

AMA Expands Continuing Medical Education Opportunities in 1977.

Now you can choose from 15 regional CME meetings!

Recognizing the importance of continuing medical education to its members, the AMA has greatly expanded its CME programs. During 1977, the AMA will offer 15 regional CME meetings around the country in addition to its scientific programs at both the Annual Convention and Winter Meeting.

The purpose of the regional programs is to make it easier and more convenient for you to continue your medical education by bringing the meetings closer to your hometown and by scheduling them on the weekends to avoid interference with your practice.

All courses are approved by the AMA Council on Continuing Physician Education for Category 1 credit toward an AMA Physician's Recognition Award. A syllabi written by medical school faculties is provided with every course.

Specific information on course location, fees, academic program, faculty, and hotel reservations will be available approximately 2 months before each course date. Please write to address below at that time stating your selection(s). Print name, address, and office phone number.

1977 Regional Schedule

Tulsa, Oklahoma	January 22-23
Birmingham, Alabama	February 5-6
*Lake Tahoe, Nevada	February 11-13
Denver, Colorado	February 19-20
*Tarpon Springs, Florida	March 4-6
Detroit (Southfield), Michigan	March 26-27
New York (Westchester), New York	April 16-17
Houston, Texas	May 15
Hartford, Connecticut	September 10-11
*Lake of the Ozarks, Missouri	September 16-18
Chicago, Illinois	September 24-25
*Hot Springs (Homestead), Virginia	Sept. 30-Oct. 2
*Huron, Ohio	October 7-9
*Honolulu, Hawaii	Oct. 30-Nov. 4
Hershey, Pennsylvania	November 18-19

AMA's 126th Annual Convention

San Francisco, California	June 18-22

AMA's Winter Scientific Meeting

Miami Beach, Florida	December 10-13

AMA Spokesmanship Seminars

Chicago, Illinois (Marriott O'Hare Hotel)	August 13-14 November 12-13

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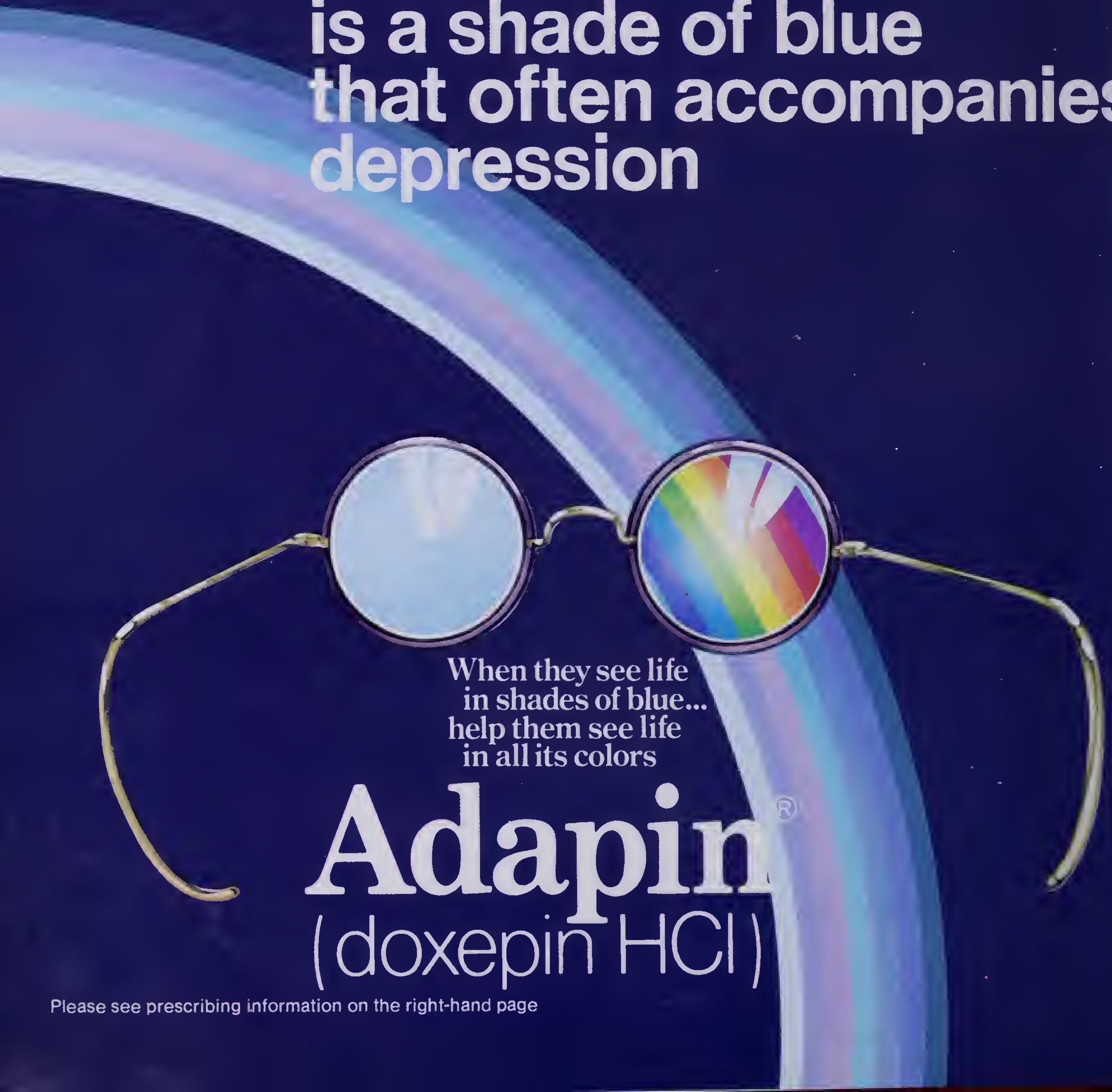
*Courses end at midday for recreation activities

AMA Department of Meeting Services
535 North Dearborn Street
Chicago, Illinois 60610

Depression comes in shades of blue

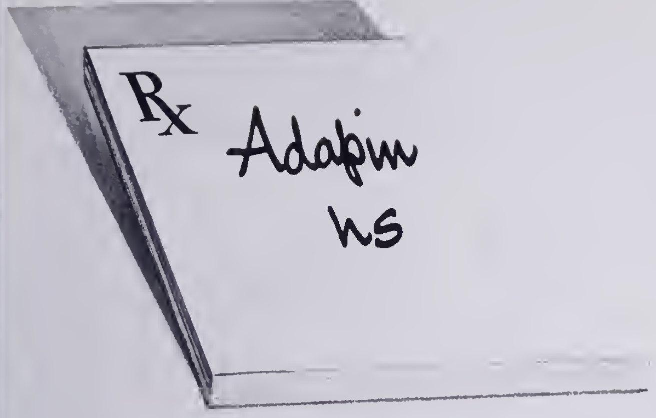
Insomnia is a shade of blue that often accompanies depression



When they see life
in shades of blue...
help them see life
in all its colors

Adapin®
(doxepin HCl)

Please see prescribing information on the right-hand page



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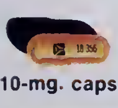
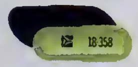


10-mg. capsules

25-mg. capsules



50-mg. capsules

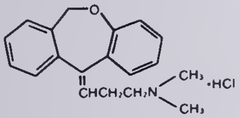
ADAPIN®

(Doxepin HCl)

Prescribing information:

DESCRIPTION

Adapin (doxepin HCl) is an isomeric mixture of N, N-dimethyl-dibenz(b,e) oxepin-$\Delta^{11(6H)}$, γ propylamine hydrochloride.



ACTIONS

Adapin has a variety of pharmacological actions with its predominant action on the central nervous system. While its mechanism of action is not known, studies have demonstrated that it is neither a monoamine oxidase inhibitor nor a primary stimulant of the central nervous system.

INDICATIONS

In controlled clinical evaluations, **Adapin** has shown marked antianxiety and significant antidepressant effects. **Adapin** has been found to be well tolerated even in elderly patients.

Adapin is indicated for the treatment of patients with:

1. Psychoneurotic anxiety and/or depressive reactions.
2. Mixed symptdms of anxiety and depression.
3. Anxiety and/or depression associated with alcoholism.
4. Anxiety associated with organic disease.
5. Psychotic depressive disorders including involutional depression and manic-depressive reactions.

Target symptoms of psychoneurosis that respond particularly well to **Adapin** include: anxiety, tension, depression, somatic symptoms and concerns, insomnia, guilt, lack of energy, fear, apprehension and worry.

Because **Adapin** provides antidepressant as well as antianxiety effects, it is of particular value in patients in whom anxiety masks depression. Patients who have not responded to other antianxiety or antidepressant drugs may benefit from **Adapin.**

In a large series of patients systematically observed for withdrawal symptoms, none were reported—a finding which is consistent with the virtual absence of euphoria as a side effect and the lack of addictive potential characteristic of this type of chemical compound.

CONTRAINDICATIONS

Because **Adapin** has an anticholinergic effect, it is contraindicated in patients with glaucoma or a tendency toward urinary retention.

Use of **Adapin** is contraindicated in patients who have been found hypersensitive to it.

WARNINGS

Usage in Pregnancy—Adapin has not been evaluated in pregnant patients. Therefore, it should not be used during pregnancy unless, in the judgment of the physician, it is essential to the welfare of the patient.

In animal reproduction studies of **Adapin (doxepin hydrochloride)**, gross and microscopic examination of the offspring gave no evidence of drug-related teratogenic effect. Following doses of up to 25 mg./kg./day for 8 to 9 months, no changes were observed in the number of live births, litter size, or lactation. A decreased rate of conception was observed when male rats were given 25 mg./kg./day for prolonged periods—an effect which has occurred with other psychotropic drugs and has been attributed to drug effect on the central and/or autonomic nervous systems.

Usage in Children—The use of **Adapin** in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors—Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with **Adapin.** The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

PRECAUTIONS

Drowsiness may occur with **Adapin;** therefore, patients should be warned of its possible occurrence and cautioned against driving a motor vehicle or operating hazardous machinery while taking the drug.

Patients should also be cautioned that the effects of alcoholic beverages may be increased.

Since suicide is an inherent risk in depressed patients and remains a risk through the initial phases of improvement, depressed patients should be closely supervised.

Although **Adapin** has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Compounds structurally related to **Adapin** can block the effects of guanethidine and similarly acting compounds. However, at the usual clinical dosages, 75 mg. to 150 mg. per day, **Adapin** has been given concomitantly with guanethidine without blocking its antihypertensive effect. But at dosages of 300 mg. per day or higher, **Adapin** has exerted a significant blocking effect.

Adapin, like other structurally related psychotropic drugs, potentiates norepinephrine response in animals. But this effect has not been observed with **Adapin** in humans, which is in accord with the low incidence of tachycardia reported clinically.

ADVERSE REACTIONS

Anticholinergic Effects: Dry mouth, blurred vision and constipation have been reported. These are usually mild, and often subside as therapy is continued or dosage reduced.

Central Nervous System Effects: Drowsiness has been observed. It usually occurs early in the course of therapy and tends to subside as therapy continues. (See Dosage and Administration section.)

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported adverse effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects (such as increased sweating), weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

DOSAGE AND ADMINISTRATION

In most patients with mild to moderate anxiety and/or depression: 10 mg. to 25 mg. t.i.d. to start. A starting dosage of 10 mg. t.i.d. for a period of four days may reduce the initial drowsiness experienced by some patients, and may be tried in cases where drowsiness is clinically undesirable. Decrease or increase the dosage at appropriate intervals according to individual response. Usual optimum dosage is 75 mg. to 150 mg. per day.

In some patients with mild symptomatology or emotional symptoms accompanying organic disease, dosage as low as 25 mg. to 50 mg. per day has provided effective control.

In more severe anxiety and/or depression: 50 mg. t.i.d. may be required to start—if necessary, gradually increase to 300 mg. per day. Additional effectiveness is rarely obtained by exceeding 300 mg. per day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

OVERDOSAGE

Symptoms—An increase of any of the reported adverse reactions, primarily excessive sedation and anticholinergic effects such as blurred vision and dry mouth. Other effects may be: pronounced tachycardia, hypotension and extrapyramidal symptoms.

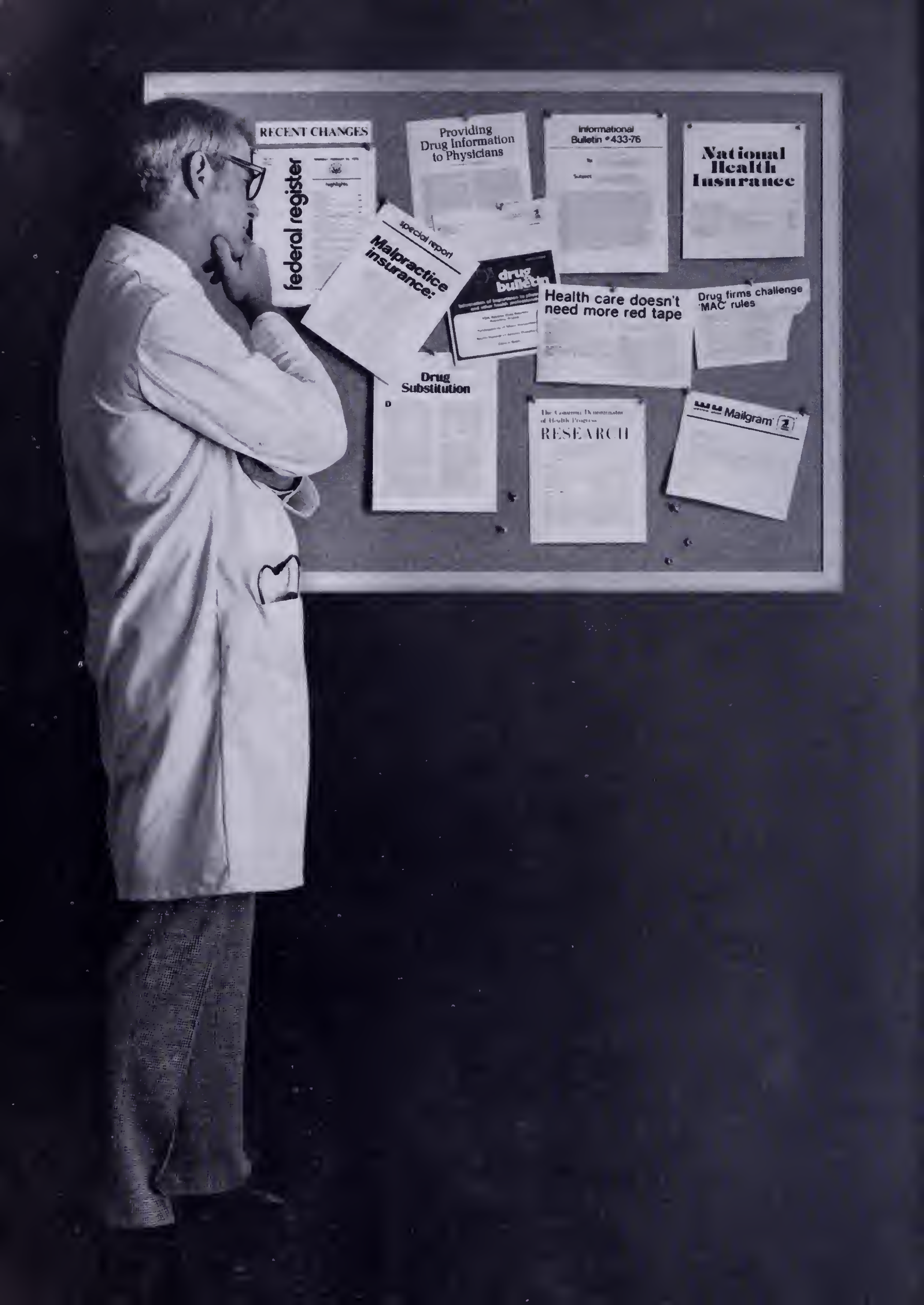
Treatment—Essentially symptomatic; supportive therapy in the case of hypotension and excessive sedation.

HOW SUPPLIED

Each capsule contains doxepin, as the hydrochloride, 10 mg. (NDC 0018-0356), 25 mg. (NDC 0018-0357), and 50 mg. (NDC 0018-0358) capsules in bottles of 100 and 1000.

PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603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Drug firms challenge 'MAC' rules
Drug Substitution
The Common Denominator of Health Progress
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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

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Meetings

(See also listing of Category I programs on page 32.)

January 19 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director

January 22-23 — Mid-Winter Seminar, State of Michigan Branch, American Association of Medical Assistants, Hyatt Regency Dearborn, contact: Helen Schulte, MSMS Headquarters

January 23-February 1 — MSMS/INTRAV Trans-Panama Canal Air/Sea Cruise, contact: Marce Ireland, MSMS Headquarters

January 28-30 — 73rd AMA Congress on Medical Education, Public Regulation, Educational Freedom, & Professional Responsibility, at Palmer House, Chicago, contact: AMA, 535 N. Dearborn, Chicago 60610

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January 30 — Conference on Occupational Disease in the Michigan Worker, sponsored by Michigan State University, at The Kellogg Center for Continuing Education, contact: Office of Conferences and Institutes, 50 Kellogg Center for Continuing Education, E. Lansing, MI 48824

February 9 — Regular meeting, Michigan Dermatological Society, Henry Ford Hospital, Detroit, contact: Richard F. Elton, MD, 15901 W. Nine Mile Rd., Southfield 48075

February 9 — Preceptor Workshop, noon-5 p.m., sponsored by Michigan Cooperative Primary Care Preceptorship Program, at Shanty Creek Lodge, Bellaire, contact: Mary Ellen Rueckert, Program Operating Committee, MSU College of Human Medicine, East Lansing 48824

February 12 — February Seminar, "Bleeding Disorders and Thromboembolic Diseases," Michigan Society of Pathologists, at Henry Ford Hospital, contact: John F. Dunkel, MD, MSU, Dept. of Pathology, E. Lansing 48824

March 2 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director

March 4 — Postgraduate Course (Category II), "Care of the Burned Patient," co-sponsored by University of Michigan Burn Center and National Institute for Burn Medicine, at Towsley Center for Continuing Education, U of M Medical Center, contact: Office of Continuing Education, Dept. of PGM-HPE, U of M

March 9 — Regular meeting, Michigan Dermatological Society, at University of Michigan, Ann Arbor, contact: Richard F. Elton, MD, 15901 W. Nine Mile Rd., Southfield 48075

March 30 — Annual Legislative Day, MSMS Auxiliary, at Olds Plaza, Lansing, contact: Helen Schulte, MSMS Headquarters

April 14-17 — Annual Meeting, State of Michigan Branch, American Association of Medical Assistants, Kalamazoo Civic Center, Kalamazoo, contact: Mrs. Ginger Hyatt, Chairman, 2533 Cumberland St., Kalamazoo 49007

April 20 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, Director

April 19-21 — International Symposium on "Human Ovulation" at C. S. Mott Center for Human Growth and Development, Wayne State University School of Medicine, Detroit, contact: E. S. E. Hafez, MD, Mott Center

May 2-4 — 51st Annual Convention, MSMS Auxiliary, Troy Hilton, Troy, contact: Mrs. F. P. Rhoades, 272 Ashland Avenue, Detroit 48215

May 6 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director

May 13-15 — 1977 Annual Session, MSMS House of Delegates, Troy Hilton, Troy, contact: Richard Campau, MSMS Headquarters

May 14 — May Seminar, "Lymphoreticular Disorders," Michigan Society of Pathologists, at Hurley Hospital, Flint, contact: Jacob E. Briski, MD, Saint John Hospital, 22101 Moross Road, Detroit 48236

June 15 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director

The Blues' answers to common MVF queries

By Neal L. McCue
Detroit

Though it was 1968 when the Blue Cross and Blue Shield of Michigan MVF concept for reimbursement to physicians was initiated, questions still are asked about this payment technique.

The following information is offered to clarify the common questions:

(1) Why doesn't BCBSM pay me the amount shown on my profile?

A. Regardless of the fee recorded on your profile, BCBSM has a maximum payment level (prevailing screen) that limits the payment made for a particular service. Therefore, if your profiled charge for a service is higher than the prevailing screen, the payable amount will be less than the amount recorded on your profile.

(2) Can I change my MVF profile?

A. Upon your written notice, the MVF Program provides for the upgrading of your profile through the fee change mechanism described in Part I of the Physician's Manual. A 90-day written notice of the desired change must be provided, listing your old fee and the requested new fee using the Michigan Uniform Procedure Code and Nomenclature (July, 1976) for each procedure to be changed. The request should include documentation of pertinent reasons for the change and be signed by the doctor. If you specify a priority sequence for the procedure codes you wish updated, we will allocate the available additional payout as limited by our cost control program in the order designated on your request.

All physicians are encouraged to examine their profiles periodically to insure that their fees are in line with their operating expenses. To do otherwise could be a disservice to both the physician and his patients. Since the claims pricing logic in the computer uses the lesser of the reported charge on the claim, the profiled charge, or the prevailing screen, an out-of-date profile could produce underpayments. Present BCBSM policy permits changes in the profile once in any given 12-month period in the event it is necessary to increase fees.

Mr. McCue is vice president for professional relations Blue Cross/Blue Shield of Michigan.

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Richard D. Watkins, M.D.
Robert M. Zimmerman, M.D.

Category I Courses

Michigan Medicine *each month will carry a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of the new Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing will indicate a contact person, so the physician can obtain details. The list will be expanded as courses are developed by accredited sponsors. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.*

The following have been accredited by MSMS Commission on Continuing Medical Education as of Sept. 1, 1976.

Organizations:

- Ann Arbor Psychiatric Association
- Michigan Academy of Family Physicians
- Michigan Academy of Plastic Surgery
- Michigan State Medical Society
- Michigan Chapter, American Academy of Pediatrics
- Michigan Dermatological Society
- Michigan Heart Association
- Michigan Lung Association, Lansing
- Michigan Society of Anesthesiologists
- University of Michigan School of Public Health

Hospitals:

- Alma-Gratiot Community Hospitals, Alma
- William Beaumont Hospital, Royal Oak
- Beyer Memorial Hospital, Ypsilanti
- Blodgett Memorial Hospital, Grand Rapids
- Bon Secours Hospital, Grosse Pointe
- Burns Clinic Med. Center, PC/Little Traverse Hospital, Petoskey
- Butterworth Hospital, Grand Rapids
- Detroit-Macomb Hospital Association
- Ferguson-Droste-Ferguson Hospital, Grand Rapids
- Grace Hospital, Detroit
- Henry Ford Hospital, Detroit
- Holy Cross Hospital, Detroit
- Hurley Medical Center, Flint
- Ingham Medical Center, Lansing
- Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital), Muskegon
- McLaren General Hospital, Flint
- Mercy Hospital, Port Huron
- Mt. Carmel Mercy Hospital & Med. Center, Detroit
- Munson Medical Center, Traverse City
- North Detroit General Hospital, Detroit
- Oakland Medical Center, Pontiac
- Oakwood Hospital, Dearborn
- Pontiac General Hospital, Pontiac
- Port Huron Hospital CME Committee
- Providence Hospital, Southfield
- Saginaw Cooperative Hospitals Inc., Saginaw
- Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
- St. Francis Hospital, Escanaba
- St. John Hospital, Detroit
- St. Joseph Hospital, Flint
- St. Joseph Mercy Hospital, Pontiac
- St. Joseph Mercy Hospital, Ann Arbor
- St. Lawrence Hospital, Lansing
- St. Mary's Hospital, Grand Rapids
- Sinai Hospital of Detroit, Detroit
- Edward Sparrow Hospital, Lansing
- Traverse City State Hospital, Traverse City
- V. A. Hospital, Battle Creek
- Wayne County Psychiatric Hospital, Eloise
- Ypsilanti State Hospital, Ypsilanti

DATE: January 13, Newer Concepts of Coronary Heart Disease: with Henry D. McIntosh, MD, Baylor Medical College
LOCATION: St. Joseph Mercy Hospital, Pontiac
SPONSOR: Oakland Medical Center and St. Joseph Mercy Hospital
FOR: Cardiologists, other interested physicians
COST: None
CONTACT: Jerome Rosenthal, PhD, Coordinator of Medical Education, St. Joseph Mercy Hospital, Pontiac, or Donald Dawson, MD, Medical Director, Oakland Medical Center, Pontiac
APPROVED FOR: 2 hours of Category I Credit

* * *

DATE: Jan. 17-21, Topics in Emergency Medicine
LOCATION: Scott Hall, Wayne State University, 540 E. Canfield, Detroit 48201
SPONSOR: WSU Department of Surgery
FOR: All interested physicians
COST: $150
CONTACT: WSU Division of CME**
APPROVED FOR: 30 hours of Category I Credit

* * *

DATE: Jan. 18, Detroit Cancer Club Seminar, Carcinoma of the Lung
LOCATION: Wayne County Medical Society headquarters, 1010 Antietam, Detroit, 48207
SPONSOR: WSU School of Medicine, Department of Oncology
FOR: All interested physicians
COST: $20
CONTACT: WSU Division of CME** or Melvin L. Reed, MD, 4160 John R., Detroit, 48201
APPROVED FOR: 2½ hours of Category I Credit

* * *

DATE: Jan. 19, Lecture Series in Ophthalmology, "Indications for and Complication of Keratoplasty"
LOCATION: Sinai Hospital of Detroit
SPONSOR: Sinai Hospital
FOR: Ophthalmologists
COST: No charge
CONTACT: Department of CME, Sinai Hospital of Detroit****
APPROVED FOR: 2 hours of Category I Credit

(Continued on page 39)

something you might have overlooked...

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Doctor MacPhail

Outcome of negotiations: we must cooperate!

(The following is a response to the recent article in the November issue of Michigan Medicine, *"Michigan physicians and the Blues – a chronological report of the latest face-off," written especially for* MM *by Jean Pearson, Detroit. Doctor MacPhail relates his version of the recent negotiations between physicians and the Blues.)*

By Albert MacPhail, MD Flint

In the fall of 1975, Blue Cross/Blue Shield of Michigan needed a huge rate increase to pay for the services their subscribers were using at ever-increasing and record-breaking levels. Application was made to the insurance commissioner for approval of the new rates, and hearings and procedural mechanics began.

Balanced against BCBSM claims concerning expanded and increased benefits and services were the insurance commissioner's statements about the Blues' mismanagement, inefficient cost containment programs and lack of effective utilization review in the case of excessive and "unnecessary X-ray and laboratory benefits." The rate increase which was finally granted was less than asked for and had many strings attached. During the months that followed many radiologists and pathologists twitched when those strings were pulled.

During the winter, a paper entitled "1976 Program Initiative: Utilization of Laboratory and X-Ray Services" was prepared by the insurance commissioner's staff. The main thrust of this paper was that "unnecessary, and thus excessive, utilization of lab and X-ray services is a major problem in Michigan" and BCBSM does not seem to be sufficiently concerned about this problem. Any rate increase must be contingent on expression of proper concern and appropriate action by BCBSM, said the commissioner's staff. Among the actions considered appropriate were development of an improved data base concerning lab and X-ray services, education of referring physicians by use of cost audit reports to modify their ordering behavior and alteration of physician reimbursement policies to delete those methods which seemed to be more expensive.

To this end, several papers and reports were prepared by the staff of BCBSM and on June 15, 1976, a letter went out to radiologists and pathologists of Michigan stating that a moratorium had been placed on separate billing. An internal report detailed a complete and radical change in the attitude toward financial arrangements between hospitals and so-called hospital-based physicians, an area which seemed to be clearly outside the authority of BCBSM. BCBSM staff seemed to have drawn many erroneous and illogical conclusions from their studies and the facts.

Members of MSP and MRS held several meetings with staff and Board members of BCBSM, discussing and delineating the multiple, complex problems of rising health care costs. Much more time was spent on varying views and perceptions of the problem than on possible solutions, principally because good solutions were not immediately apparent.

After considering the input from MRS, MSP, MHA, MSMS and others, the Blues' Ad Hoc Subcommittee on Hospital-Based Physician Reimbursement reported to its parent Health Care Cost Committee. Their recommendations avoided radical changes which were certain to produce divisive confrontation and litigation. They did not exclude separate billing. Under the combined billing option they proposed reimbursement limitations based on reasonableness without explaining what they really meant by this. Cost containment committees and utilization standards for lab and X-ray studies were considered absolutely necessary.

The parent committee, and subsequently the BCBSM Board, accepted those suggestions, lifted the moratorium and sent letters to this effect to hospital administrators, radiologists and pathologists throughout Michigan. Victor Curatolo, MD, president of MRS, has appointed a task force to work with BCBSM on the formulation of administrative guidelines for setting up utilization standards for diagnostic radiology. While establishing the task force, he reiterated the necessity of all physicians being involved early in this process.

At this writing, the response of BCBSM to these offers of assistance

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Doctor MacPhail is chairman, Liaison Committee, Michigan Radiological Society.

and cooperation is not known. It seems very likely to me that they will be glad to embrace this teamwork approach.

Can this long series of events be capsulized slightly cynically in a theatrical analogy? I think it can.

I believe that we (pathologists and radiologists) were unwilling actors conscripted into a hastily patched-together play (Act I — BCBSM staff studies followed by a moratorium on separate billing; Act II — meetings with staff and subcommittee; Act III — Blues' partial reversal of untenable position, establishment of cost containment committees and utilization review standards and lifting of moratorium) which was written, produced and directed by somewhat reluctant talents (BCBSM) for a powerful and essentially invisible audience of one (the insurance commissioner of the State of Michigan).

EPILOGUE: We must do our best to establish communications with the insurance commissioner and his staff and offer our cooperation and expertise in any future studies on radiology in Michigan.

Encore, Anyone?

Single Business Tax to be revised, not repealed

By C. O. Long, MD
Lansing

The Single Business Tax was signed into law on August 27, 1975, by Gov. William G. Milliken. The SBT is considered a "value added tax" and as such it represents a tax upon "the privilege of doing business in Michigan," and not upon income. The tax base is calculated from (1) compensation paid, (2) depreciation, (3) royalties paid, (4) interest paid, (5) fringe benefits, (6) FICA, (7) workman's compensation, and (8) unemployment compensation.

This new tax replaces seven previous business taxes: (1) the corporate income tax, (2) property tax on inventory, (3) income tax on financial

---

Doctor Long is a radiologist and the only physician member of the Governor's Special Task Force on the SBT.

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institutions, (4) corporate franchise tax, (5) intangibles tax, (6) savings and loan privilege fee and (7) domestic insurance carrier's fee.

The two major reasons indicated by Gov. Milliken for devising the SBT were (1) a desire to stabilize the revenue of the State and (2) an attempt to promote business investment and expansion in Michigan.

And, to provide a tax climate more conducive to business investment and expansion, the State repealed such discouraging taxes as the corporation franchise fee and the property tax on inventory.

Labor-intensive corporations burdened

Not included as "a major reason" or a "purpose," but none-the-less calculated at the outset, was a shift in the tax burden away from capital-intensive firms, corporations with high profit margins and firms with large inventories. Labor-intensive firms, unincorporated firms, firms with low net profit margins and professionals such as doctors, lawyers and public accountants now bear a greater tax burden than under the old system. In a number of instances the increase was catastrophic.

This sudden shift in tax burden created a groundswell of controversy and a large volume of negative opinion expressed by the business community. Because of this strong dissent by those victimized by SBT, Gov. Milliken in April, 1976 appointed a 46-member task force, chaired by Lt. Gov. James J. Damman, to examine the Single Business Tax. The mandate of the task force is to:

1) Study effects of the Single Business Tax as they relate to particular businesses in Michigan.

2) Monitor impact of the SBT on the level of economics and business activity.

3) Recommend to the Governor any specific changes that might appear to be needed.

The task force has divided itself into five major committees along industry lines. These are: Manufacturing, Trade and Construction, Services, Professionals and Resource-based industries. As the only physician on the task force, I serve on The Professional Subcommittee which is chaired by Raymond Smit, Ann Arbor, a consulting engineer and former Republican state representative.

Our subcommittee has emphasized in its reports to the Task Force that while the idea of simplifying the business tax procedure and developing a greater element of stability in the State revenue may be a noble goal, the heavy shift of tax burden to the small businesses, the unincorporated businesses and the labor-intensive businesses is grossly inequitable.

Survey reveals views of SBT

In an effort to evaluate the effects of SBT on the Michigan business community, the SBT Task Force surveyed 4,000 firms in August 1976. Although too small a response was made for a significant interpretation, the analysis demonstrated nearly two-thirds of the respondents disagreeing with the SBT concept and over 80% disagreeing with the specific formula used. Nearly 75% felt that there are features of the SBT formula that should be changed, with nearly half declaring to be in favor of a profits tax or a return to the old system (repeal of SBT). On the other hand, over 25% saw features of the SBT worth retaining, with a third of these agreeing that the tax does simplify tax preparation and filing. MSMS' state-wide survey of physicians through *Medigram* also produced a disappointing response of only 15%, but revealed an average SBT payment of $1614 for 1975, compared to an average payment of $156 under the old system.

Dr. Long

The Task Force, in its interim report to the Governor Oct. 28, 1976, acknowledged that additional study for alternative action is needed in the following areas:

(1) Small business/low profit relief
(2) Relief for labor intensive industry
(3) Job creation proposals
(4) Greater consideration of "ability to pay"
(5) Better treatment of depreciation and interest

Changes imminent in SBT law

In an effort to gain additional information on the impact of SBT, the task force has conducted public hearings at various cities around the state. Results of testimony at the hearings will be gathered and analyzed for a report to be issued probably in late January.

It is my feeling from the manner in which work has been proceeding that the likelihood is not for repeal, but for changes in the law. They probably will provide relief for hardship situations, allow consideration of profits in addition to tax of gross business and provide some incentive for the creation of jobs.

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Warnings: **Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K^+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy.** Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium® (triamterene, SK&F Co.), and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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DATE: Jan. 24-28, Family Practice Review

LOCATION: Towsley Center, Ann Arbor

SPONSOR: U of M Office of Intramural Education

CO-SPONSOR: Michigan Association of Family Physicians

FOR: Family physicians

COST: $250

CONTACT: U of M Office of Intramural Education*

APPROVED FOR: 37½ hours of Category I Credit

* * *

DATE: Jan. 26, What's new in Obstetrics?

LOCATION: Saint John Hospital, Detroit

SPONSOR: Saint John Hospital

FOR: Obstetricians

COST: $50

CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital, 22101 Moross Road, Detroit, 48236

APPROVED FOR: 7 hours of Category I Credit

* * *

DATE: January 26, Gastric and Pancreatic Carcinoma

LOCATION: Grace Central Hospital Student Nurses Auditorium

SPONSOR: Wayne State University School of Medicine

FOR: All interested physicians

COST: $20

CONTACT: WSU Department of CME**

APPROVED FOR: 2½ hours of Category I Credit

* * *

DATE: Feb. 2, Tumors of the Bone — Primary and Metastatic

LOCATION: Grace Central Hospital

SPONSOR: WSU School of Medicine

FOR: All interested physicians

COST: $20

CONTACT: WSU Department of CME**

APPROVED FOR: 2½ hours of Category I Credit

* * *

DATE: Feb. 16, Lecture Series in Ophthalmology, "The CO_2 Laser in Ocular Surgery"

LOCATION: Sinai Hospital of Detroit

SPONSOR: Sinai Hospital

FOR: Ophthalmologists

COST: No charge

CONTACT: Department of CME, Sinai Hospital of Detroit****

APPROVED FOR: 2 hours of Category I Credit

* * *

DATE: Feb. 17 — Live color TV presentation of gynecological urethroscopy, with Jack Robertson, MD, associate clinical professor, Department of Ob/Gyn, Woman's Hospital, University of Southern California Medical Center

LOCATION: E. W. Sparrow Hospital, Lansing

SPONSOR: E. W. Sparrow Hospital and Michigan State University College of Human Medicine

CO-SPONSOR: Lansing Obstetrical-Gynecological Society

FOR: All interested physicians

COST: $3 for lunch, $15 for banquet

CONTACT: Ann Tsiminakis, Conference Coordinator, Kellogg Center for Continuing Education, Michigan State University, East Lansing, 48824

APPROVED FOR: 4 hours of Category I Credit

* * *

DATE: Feb. 20-25, Second Annual Seminar on Emergencies in Medicine

LOCATION: Boyne Highlands, Harbor Springs

SPONSOR: Wayne State University School of Medicine

CO-SPONSOR: Michigan Committee on Trauma, American College of Surgeons

FOR: All interested physicians

COST: $35 for physicians, $15 for other health professionals

CONTACT: Robert F. Wilson, MD, (313) 224-0743

APPROVED FOR: 25 hours of Category I credit

* * *

DATE: Feb. 21-25, Emergency Medicine

LOCATION: Towsley Center, Ann Arbor

SPONSOR: U of M Office of Intramural Education*

CO-SPONSOR: American College of Emergency Physicians, Michigan Chapter

FOR: Emergency physicians

COST: $225 for physicians; $135 for physicians in training

CONTACT: U of M Office of Intramural Education*

APPROVED FOR: Approx. 36¼ hours of Category I Credit

* * *

DATE: February 21-April 25, Pediatric Seminars - II

LOCATION: Saint John Hospital, Detroit

SPONSOR: Saint John Hospital

FOR: Pediatricians

COST: $200

CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital, 22101 Moross Road, Detroit, 48236

APPROVED FOR: 20 hours of Category I Credit

* * *

DATE: March 1, Pathology Conference

LOCATION: Towsley Center, U of M Medical Center

SPONSOR: U of M Medical Office of Intramural Education

FOR: Pathologists

COST: $60

CONTACT: U of M Office of Intramural Education*

APPROVED FOR: Approximately 6 to 7 hours of Category I Credit

* * *

DATE: March 2, "Cell Kinetics as Related to Cancer Therapy," with Dr. Emil J. Freireich — visiting lecturer

LOCATION: Zuckerman Auditorium, Sinai Hospital of Detroit

SPONSOR: Sinai Hospital Department of Medicine

FOR: Internists, Hematologists, Oncologists

COST: None

CONTACT: Arnold R. Axelrod, MD, Sinai Hospital, (313) 272-6000

APPROVED FOR: 2 hours of Category I Credit

* * *

---

*Office of Intramural Education, University of Michigan Medical Center, Dep't. of PGM/HPE, Ann Arbor, 48109

**WSU Division of CME, Room 1209, Scott Hall, 540 E. Canfield, Detroit, 48201 (313) 577-1453

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902

****Department of CME, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 272-6000

DATE: March 2-3, Advances in Pediatrics
LOCATION: Towsley Center, U of M Medical Center
SPONSOR: U of M Office of Intramural Education
CO-SPONSOR: Mich. Chapter, American Academy of Pediatrics
FOR: Pediatricians
COST: $120
CONTACT: U of M Office of Intramural Education*
APPROVED FOR: 13¾ hours of Category I Credit

* * *

DATE: March 14-15, Difficult Problems Encountered in the Practice of General Surgery
LOCATION: Towsley Center, U-M Medical Center
SPONSOR: U of M Office of Intramural Education
FOR: Surgeons
COST: Approximately $120
CONTACT: U of M Office of Intramural Education*
APPROVED FOR: Approximately 13 to 14 hours of Category I Credit

* * *

DATE: March 15, Cancer of the Colon and Rectum
LOCATION: Wayne County Medical Society headquarters, 1010 Antietam, Detroit, 48207
SPONSOR: WSU Department of Oncology
FOR: All interested physicians
COST: $20
CONTACT: WSU Division of CME**
APPROVED FOR: 2½ hours of Category I Credit

* * *

DATE: March 16, Lecture Series in Ophthalmology, "The Treatment of Lid Elevation"
LOCATION: Sinai Hospital of Detroit
SPONSOR: Sinai Hospital
FOR: Ophthalmologists
COST: No charge
CONTACT: Department of CME, Sinai Hospital of Detroit****
APPROVED FOR: 2 hours of Category I Credit

* * *

DATE: March 20-June 8, Clinical Nuclear Medicine II
LOCATION: Scott Hall, Wayne State University
SPONSOR: WSU Department of Radiology
FOR: Radiologists
COST: $66
CONTACT: WSU Division of CME**
APPROVED FOR: 20 hours of Category I Credit, 2 hours per session

* * *

DATE: March 23, Infant Nutrition: A Foundation for Lasting Health
LOCATION: Veteran's Memorial Building, 151 West Jefferson Avenue, Detroit
SPONSOR: The University of Iowa College of Medicine, and the National Heart, Lung and Blood Institute
CO-SPONSOR: The National Kidney Foundation, The Committee on Atherosclerosis and Hypertension in Childhood, and the Council on Cardiovascular Disease in the Young of the American Heart Association
FOR: All interested physicians, via a closed circuit symposium
COST: None
CONTACT: Pat Coleine, Health Learning Systems, Inc., c/o Health Projects International, Inc., 200 Madison Avenue, New York, 10016
APPROVED FOR: 34 hours of Category I Credit, (The TV symposium: 3 hours, Pre & Post Tests: 14 hours, Supplementary study: 8 hours, Visiting Faculty: 9 hrs)

* * *

DATE: March 23, Heart Day
LOCATION: Saint John Hospital, Detroit
SPONSOR: Saint John Hospital
FOR: Cardiologists
COST: $50
CONTACT: Linda Radu, Dept. of Medical Education, St. John Hospital, 22101 Moross Road, Detroit, 48236
APPROVED FOR: 7 hours of Category I Credit

* * *

DATE: March 23, Carcinoma of the Uterus
LOCATION: Grace Central Hospital
SPONSOR: WSU School of Medicine
FOR: All interested physicians
COST: $20
CONTACT: WSU Department of CME**
APPROVED FOR: 2½ hours of Category I Credit

* * *

DATE: March 23 - June 7, Physics of Nuclear Medicine and Diagnostic Radiology
LOCATION: Scott Hall, Wayne State University
SPONSOR: WSU Department of Radiology
FOR: Radiologists
COST: $66
CONTACT: WSU Division of CME**
APPROVED FOR: 20 hours of Category I Credit, 2 hours per session.

* * *

DATE: March 26-27, AMA Regional Program
LOCATION: Michigan Inn, Southfield
SPONSOR: AMA and MSMS
FOR: All interested physicians
COST: $10 per credit hour
CONTACT: AMA Council on Scientific Assembly, 535 N. Dearborn, Chicago 60610
APPROVED FOR: To be determined

* * *

DATE: March 30-31 — Annual Michigan Conference on Maternal and Perinatal Health
LOCATION: Kalamazoo Center Inn, Kalamazoo
SPONSOR: MSMS
FOR: All interested physicians
COST: None
CONTACT: Herbert Auer, MSMS headquarters
APPROVED FOR: Tentative 7 hours of Category I credit

(Continued on page 42)

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DATE: April 4-June 18, Medical Cytogenetics
LOCATION: Scott Hall, WSU School of Medicine
SPONSOR: WSU Department of Pathology
FOR: Pathologists
COST: $100
CONTACT: WSU Division of CME**
APPROVED FOR: 20 hours of Category I Credit, 2 hours per session

* * *

DATE: April 5-6, Obstetrics and Gynecology Conference
LOCATION: Towsley Center, U of M Medical Center, Ann Arbor
SPONSOR: U of M Office of Intramural Education
FOR: Obstetricians/Gynecologists
COST: $100.
CONTACT: U of M Office of Intramural Education****
APPROVED FOR: 11½ hours of Category I Credit

* * *

DATE: April 6, Dermatology for the Generalist and Internist
LOCATION: Zuckerman Auditorium, Sinai Hospital of Detroit
SPONSOR: Sinai Hospital
FOR: Dermatologists, internists and generalists
COST: To be determined
CONTACT: Office of CME, Sinai Hospital, 6767 W. Outer Drive, Detroit 48235, (313) 272-6000
APPROVED FOR: 3 hours of Category I Credit

* * *

DATE: Every Friday, through July, 1977, Neurology Conference
LOCATION: 4 Morse Auditorium, Harper Hospital
SPONSOR: Wayne State University Department of Neurology
FOR: Internists, neurologists, neurosurgeons, pediatricians, family doctors
COST: None
CONTACT: Beverly Wolf, Department of Neurology, 3990 John R, Detroit, 48201
APPROVED FOR: 2 hours Category I Credit

* * *

DATE: Every Saturday, Weekly Conference
LOCATION: Gamble Building, Burns Clinic/Little Traverse Hospital, Petoskey
SPONSOR: Burns Clinic/Little Traverse Hospital
FOR: All interested physicians
COST: None
CONTACT: Ernest W. Carpenter, MD, 560 West Mitchell, Petoskey, 49770

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* * *

DATE: Begins September, 1976, Continuing Training in Family Therapy
LOCATION: Suite 1212, North Park Plaza, 17117 W. Nine Mile Road, Southfield
SPONSOR: Family Institute of Southeastern Michigan
CO-SPONSOR: Ackerman Institute
FOR: Psychotherapists
COST: Varies according to time put in
CONTACT: Carolyn R. Tourkow, MSW, director, Family Institute of Southeastern Michigan
APPROVED FOR: Hours vary with time spent

* * *

DATE: Saturdays, Morbidity and Mortality Conference
LOCATION: Sinai Hospital of Detroit
SPONSOR: Sinai Hospital Department of Surgery
FOR: Surgeons
COST: None
CONTACT: Office of CME, Sinai Hospital of Detroit****
APPROVED FOR: 2 hours of Category I Credit per session

* * *

DATE: Monthly, Cleft Palate Clinic
LOCATION: Sinai Hospital of Detroit
SPONSOR: Sinai Hospital
FOR: Oral Surgeons, plastic surgeons, pediatricians
COST: None
CONTACT: Office of CME, Sinai Hospital of Detroit****
APPROVED FOR: 3 hours of Category I Credit

* * *

DATE: Monthly, Tissue Audit (Cancer)
LOCATION: Sinai Hospital of Detroit
SPONSOR: Sinai Hospital
FOR: Surgeons, ob-gyns, pathology, radiology
COST: No charge
CONTACT: Office of CME, Sinai Hospital of Detroit****
APPROVED FOR: 2 hours per session Category I Credit

* * *

DATE: Second Thursday of each month, Inter-Hospital Pathology Slide Conference
LOCATION: St. John Hospital, Detroit
SPONSOR: St. John Hospital
FOR: Pathologists
COST: No charge
CONTACT: Department of CME, St. John Hospital, 22101 Moross Road, Detroit, 48236, (313) 881-8200
APPROVED FOR: 3 hrs. each date Category I Credit

* * *

DATE: Every Tuesday morning, Gynecology/Obstetrics Combined Grand Rounds
LOCATION: Jackson Auditorium, Hutzel Hospital
SPONSOR: Wayne State University Department of Gynecology-Obstetrics
FOR: All interested physicians
COST: No charge
CONTACT: Wayne State University, Division of CME**
APPROVED FOR: 4 hours each of Category I Credit

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Doctor Stapleton remembered

By Judith Marr
Managing Editor

Doctor Stapleton

One of Michigan's most beloved and well-known physicians, William J. Stapleton, Jr., MD, Detroit, died Nov. 19 at the age of 99. He would have been 100 on Christmas Day.

Known to thousands of Detroit-area persons in and out of the medical field as "Doctor Bill," he had been in practice for 68 years. He was honored by MSMS in 1953 as "Michigan's Foremost Family Physician," and made house calls until the age of 78, when he suffered a lame knee.

Doctor Stapleton was official historian for MSMS until recent years and was considered the foremost authority on Michigan medical history. The Stapleton Reading Room of the WSU Shiffrin Medical Library is named in his honor.

For years, he also reviewed "100 books for the Doctor" and published those reviews in the *Detroit Medical News*, for which he was official biographer. His commentary on his European trips appeared for many years in *Michigan Medicine* under the title, "The Doctor's Log."

Doctor Stapleton was on the faculty of Wayne State University Medical School for 37 years and served as medical school associate dean from 1939 to 1949. He taught WSU medical students until he was 70 years old.

He was in the first four-year class to graduate from the old Michigan College of Medicine and Surgery in 1899 and he also earned a degree from the Detroit College of Law. Wayne State University awarded him an honorary degree in 1949.

Doctor Stapleton was born in Detroit in 1876 and remained a lifelong resident. His love for Detroit "never flagged," reported a recent edition of the Detroit *News*.

Doctor Stapleton's career began as an intern, when he clung to the back of horse-drawn ambulances as they clattered down cobblestone streets and wore a cap marked "surgeon" on his head. Later, he made house calls in his Model T. He first hung his shingle in front of his downtown Detroit office in 1900 and charged $1 per call.

He just retired nine years ago, and at that time was believed the oldest practicing physician in the US.

Doctor Stapleton was past president of the Detroit Academy of Medicine, past president of the Wayne County Medical Society, and former chairman of the MSMS Medico-Legal Committee. He was a member of the Detroit Academy of Medicine, Detroit Medical Club, American Association for the Advancement of Science, American Association of Medical History, Prismatic Club and the Founders Society of the Detroit Institute of Arts. He was a fellow of the American College of Physicians.

"Although Doctor Stapleton missed by only 36 days his hundredth birthday," eulogized F. P. Rhoades, MD, in a recent issue of *Detroit Medical News*, "he will live forever in the hearts and minds of the countless thousands of physicians and patients he inspired by his kindness, integrity and friendship."

Michigan MDs now featured on three TV panel shows

MSMS now is assisting county medical societies with three "ask the doctor" television programs around the state.

The original program, "Housecall," continues for the second year under the joint sponsorship of the Wayne, Oakland and Macomb county medical societies at 8:30 p.m. the third Thursday of every month on Channel 56, Detroit.

A new "Ask the Doctor" program now appears at 1:30 p.m. the first Sunday of each month over Channel 13, WZZM, Grand Rapids, sponsored by the Kent County Medical Society. Jack Lukens, MD, is in charge of the project there.

Another new program, "Housecall," is aired at 8 p.m. the first Thursday of each month over Channel 19 in the Bay City area, where Richard Hausler, MD, leads Bay County Medical Society efforts there.

All three programs feature a panel of physicians answering questions from viewers.

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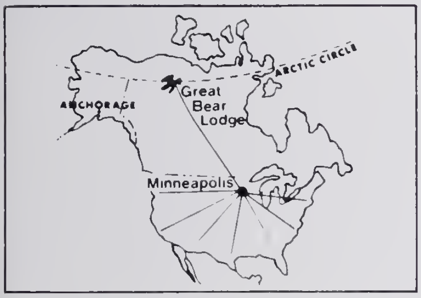

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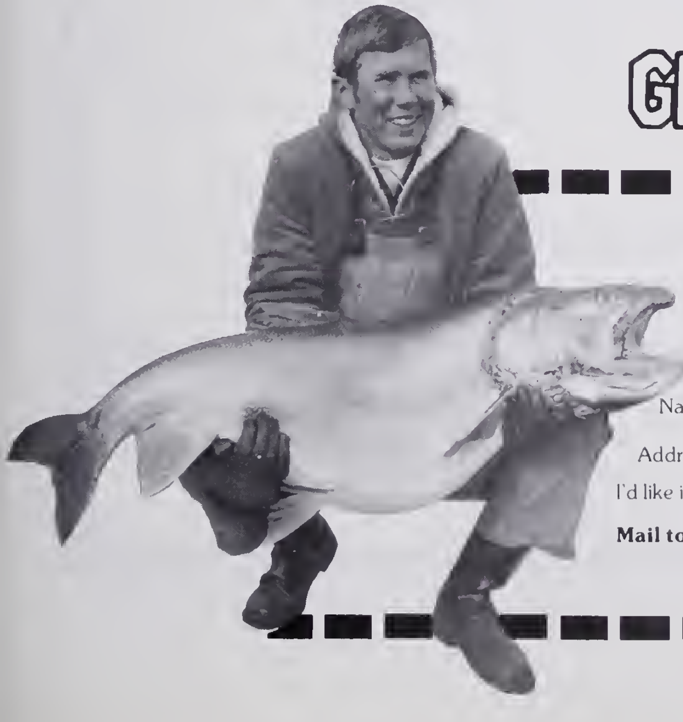

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In Memoriam

Louis M. Harley, MD
Bloomfield Hills

Detroit pediatrician Louis M. Harley, MD, died Nov. 9 at the age of 71. Doctor Harley was affiliated with Childrens, Harper, Sinai and North Detroit General hospitals. He was a member of the Detroit Pediatric Society and the Michigan Allergy Society. He was a graduate of the University of Michigan Medical School.

Homer E. Cornell, MD
Muskegon

Muskegon obstetrician/gynecologist Homer E. Cornell, MD, died Nov. 26 in an airplane crash. He was 45. Doctor Cornell had practiced in Muskegon since 1962 and was affiliated with Hackley and Mercy hospitals there, as well as Oceana Hospital, Hart. He was a graduate of Temple University Medical School and was a diplomate of the American College of Obstetricians/Gynecologists. He was active in the Michigan Society of Obstetricians and Gynecologists and in the Muskegon Area Planned Parenthood Association.

Albert DeGroat, MD
Detroit

Albert DeGroat, MD, retired Detroit pathologist, died Nov. 6 at the age of 79. Doctor DeGroat was director of laboratories and pathology at Herman Kiefer Hospital from 1955 to 1966. He also was pathology professor with the Medical School of Arkansas and on the faculty of Baylor University. He was past president of the Michigan Pathology Society, a graduate of Rush Medical School and a member of several specialty societies.

William E. Johnston, MD
Detroit

William Ealing Johnston, MD, Detroit surgeon since 1923, died Nov. 22 at the age of 81. Doctor Johnston had been chief of surgery at Hutzel Hospital from 1932 to 1952 and served as senior attending surgeon there until his retirement in 1970. He previously was affiliated with Henry Ford Hospital. He was a fellow of the American College of Surgeons, a member of the American Board of Surgery and the Royal College of Surgeons. He was graduated from the University of Toronto medical school.

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Joseph S. Leszynski, MD
Detroit

Joseph S. Leszynski, MD, Harper Hospital, Detroit surgeon for 40 years, died Nov. 5 at the age of 87. He was a graduate of the University of Michigan Medical School and had served with the U.S. Navy in World War I.

Raymond D. Schirack, MD
Waters

Retired pediatrician Raymond D. Schirack, MD, died recently at the age of 85. Doctor Schirack was a graduate of Wayne State University Medical School and had served in World War I.

John H. Yff, MD
Zeeland

Zeeland family physician John H. Yff, MD, died Nov. 24 at the age of 54. He was a graduate of Wayne State University School of Medicine and had practiced in Zeeland since 1954. He was chief of staff of Zeeland Hospital several times. He was a member of the American Association of Abdominal Surgeons.

MSMS Travel Tours now awaiting MDs' reservations

MSMS members may make travel plans now for two exciting MSMS-sponsored travel medical seminar programs for 1977. The first is an Alps/Riviera Adventure May 31-June 13 to Switzerland, Italy and France. Cost is $1,398 per person, and includes transportation, hotels and meals.

The second is an Around the World Adventure Sept. 5-Oct. 8 and includes stops in Japan, Hong Kong, India, Afghanistan, Egypt, Israel, Turkey and England. The cost is $4,995 per person complete. Both travel tours are by the exclusive MSMS non-regimented Intrav plan.

Contact Marcelyn Ireland at MSMS headquarters for further information.

Do you know
a physician with problems of alcoholism, drug abuse, or other difficulties
which interfere with his abilities to practice medicine?
If so, please contact your MSMS Committee to Assist Impaired Physicians, through Mrs. Davis at MSMS headquarters (517) 337-1351.

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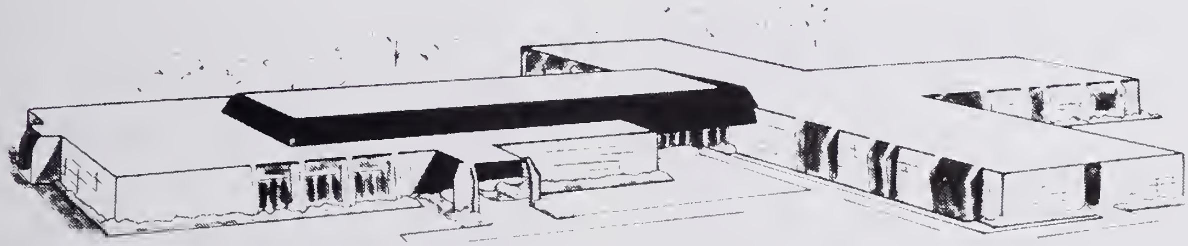

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TAX DEDUCTIBLE VACATIONS FOR MEDICAL PROFESSIONALS. Over 500 listings of national/international meetings in the medical sciences for 1977. Send a $10.00 check or money order payable to Professional Calendars, P.O. Box 40083, Washington, D.C. 20016.

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Potpourri

By Herbert A. Auer, Executive Editor

In his exaugural comments after serving as president of the Jackson County Medical Society, Edward R. Weddon, MD, told his associates that "We must treat every person who walks into our medical offices as a human being. Whether the medical profession has good public relations or not is up to each and every doctor."

* * *

A new Rand Corporation survey reports that Detroit lost 12,000 people in 1974, but the decline stopped in 1975. The 12,000 drop was much smaller proportionately than in other big cties.

* * *

"In spite of the changes that are on us, the world needs the medical profession; it needs women and men of compassion, of competence, of wisdom, of morals, tempered with an awareness of the limits of science; a personal escort through troubled times," so declared E. Grey Dimond, MD, of the University of Missouri School of Medicine, in a recent issue of *JAMA*. See Vol. 236, No. 18 for the full article.

* * *

The Texas Medical Malpractice Commission has issued its first report and found that the professional liability crisis there has boosted health care costs, restricted the availability of care and may stifle medical advances.

* * *

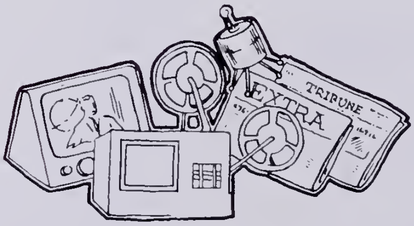
Eric Sevareid, retiring CBS newsman, has these comments about biased reporting. "You can be personally biased about something, but still approach it objectively. It's a matter of tone. My temperament is such that I would rather explain than advocate something. Maybe that is why I've been around so long."

* * *

British author Alex Comfort has issued a new book, this one about *A Good Age*. He contends that prejudice against the elderly is society's most stupid bias. He says, "Most of the handicaps of oldness in our society are social and conventional — and imaginary." He argues that "all the elderly really need is a better shake from society."

* * *

Nutrition expert Theodore P. Labuza, University of Minnesota, contends that Americans have been fed a diet of sensational, inaccurate, inadequately-researched information about food and nutrition. He blames the food industry, government, the media and the medical profession.



Physicians might be interested in ordering Pamphlet No. 415 for 25¢ about "Fads, Myths, Quacks and Your Health," from Public Affairs Pamphlets, 381 Park Avenue, South, New York, NY 10016.

* * *

Ads that are being placed in national magazines by the Health Insurance Institute pledge the support of life and health insurance companies by saying "the private insurance business, the hospital and medical professions, and good government must do together what no one sector could do alone — assure quality health care for everyone while at the same time doing everything possible to combat rising costs."

The message further declares, "Health care is people, and all of us must be cared for as people, as individuals, each with different needs."

* * *

"It may hurt the pride of some editors to acknowledge that letters to the editor often elicit more response than editorials themselves," said Charles L. Towne, editor of the Hartford, Connecticut *Courant*, at a press meeting. The MSMS Committee on Public Relations urges doctors and medical organizations to make greater use of the "letters to the editor" sections of newspapers.

* * *

Eli Lilly and Company reports that during a year it prepares 27,000 government forms at a cost of $15 million. One of Lilly's recent applications for a new drug consisted of 120,000 pages. The application with required duplicate and triplicate copies weighed more than 2,000 pounds.

* * *

A recent article in *National Observer* about continuing medical education contained the statement, "Keeping abreast of medical developments, by one estimate, requires the equivalent of three months of 40-hour weeks each year."

Contents

***Michigan Medicine*, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about contemporary issues and actions of the Michigan State Medical Society, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.**

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

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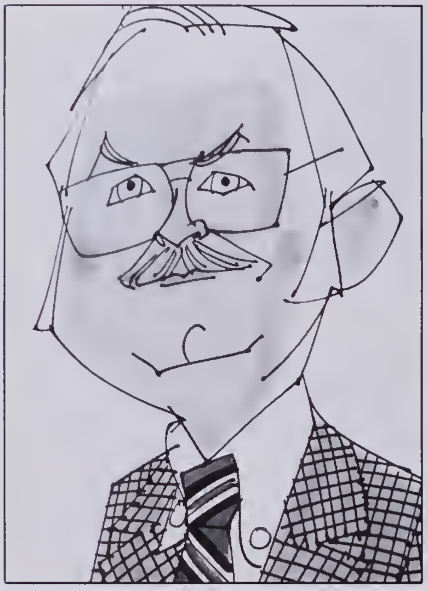
In the next issue . . .

The post-physician era?

President's Page

Physicians must anticipate confrontations between HSAs, PSROs



Robert M. Leitch, MD
MSMS President

Last month in this column I discussed the need for Michigan physicians to become more involved with the development of the new Health Systems Agencies in Michigan.

Those agencies were created by the National Health Planning and Resource Development Act of 1974 to oversee and regulate health care facility construction and other health care delivery spending. Consumer-oriented, with some provider representation, they are to be the government's watchdogs over the efficiency and costs of health care delivery. They replace the former comprehensive health planning agencies.

This month, I expand my pleas for involvement in these new organizations to ask that each MSMS member become more aware of the brewing interactions between HSAs and the older PSROs.

A comprehensive article on the issues involved appears in this issue, beginning on page 64.

A recent University of California study of potential cooperation between HSAs and PSROs concluded in its preliminary report that the two should work simultaneously, cooperate when possible, but serve to balance points of view and politics.

One of the biggest issues to be worked out between PSROs and HSAs is the sharing and gathering of health care statistics.

The problem is that PSROs are restricted in the sharing of data for confidentiality reasons. HSAs, on the other hand, are not allowed by law to gather their data, but are to contract with PSROs and other groups for the data they need.

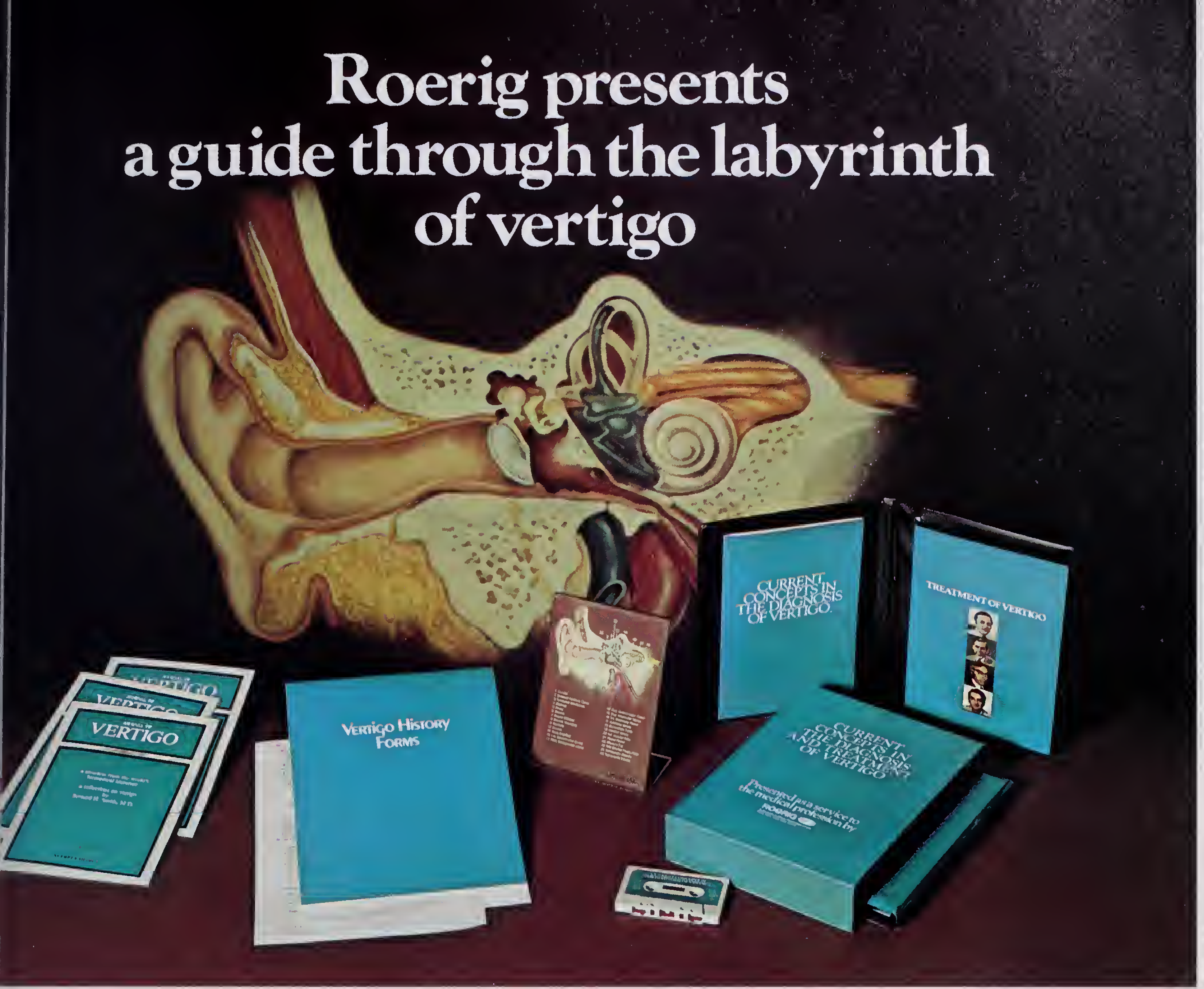
In addition, both have to work with cooperative data gathering systems designed to avoid duplication of data-gathering efforts by all groups wanting necessary information. And since the PSRO and HSA areas do not coincide, this will make it more difficult to share data.

Basically, PSROs, HSAs and cooperative health information systems want to avoid duplication, and want to work together. But they also want to maintain as much power and control as possible. Their interactions are part of the growing nationwide struggles to get and control data.

And thus it is our job as physicians to learn as much as possible about each group and its potential for ensuring good health care delivery.

The working arrangements are bound to be complicated and dynamic, rather than set and constant. Let's do our best to understand and influence them while both PSROs and HSAs are still in the formative stage.

Roerig presents a guide through the labyrinth of vertigo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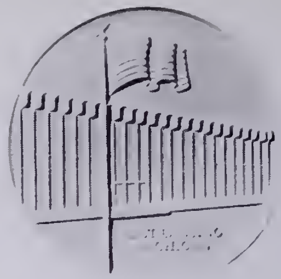

How you benefit as an MSMS member

– with your eligibility for enrollment in the MSMS group Blue Cross/Blue Shield plan for comprehensive hospital, medical and surgical care.

MSMS members and their families may enroll — immediately upon obtaining active member status — in the MSMS group hospital, medical and surgical insurance plans with Blue Cross/Blue Shield of Michigan.

There are five MSMS group insurance plans, — a basic, comprehensive plan; an "econo-plan" offering limited benefits; a hospital benefits-only plan; a plan for widows of MSMS members, and one for medical assistants. Coverage for each becomes effective within three months.

The benefits of the basic plan include 365 days of hospital care; 730 days of convalescent care; full cost of hospital room; full cost of meals, general nursing care, special diets; full cost of hospital outpatient care; full renewal of days for hospital/convalescent care after you have been out of a hospital or convalescent facility for at least 60 days; maternity and nursery care, outpatient psychiatric care, and other hospital services.

Medical-surgical care benefits include surgery and necessary post-operative care, anesthesia, obstetrical care — pre and post natal, medical care in the hospital, medical care in a convalescent facility, consultations, emergency first aid, hemodialysis, technical surgical assistance, radiological therapy, diagnostic X-rays and diagnostic laboratory and pathology services.

The plan pays the physician's reasonable charges for medical-surgical care.

Full coverage is provided for all family dependents when properly enrolled. Young adults over 19, if unmarried, dependent for more than half their support, residing with their families or temporarily at school or summer camp, also are eligible to the age of 25.

Relatives residing with the insured and dependent for more than half their support also may be covered.

Further details and rates, as well as information on the other plans, may be obtained from MSMS Dept. of Member Services, Box 950, E. Lansing, Mi. 48823.

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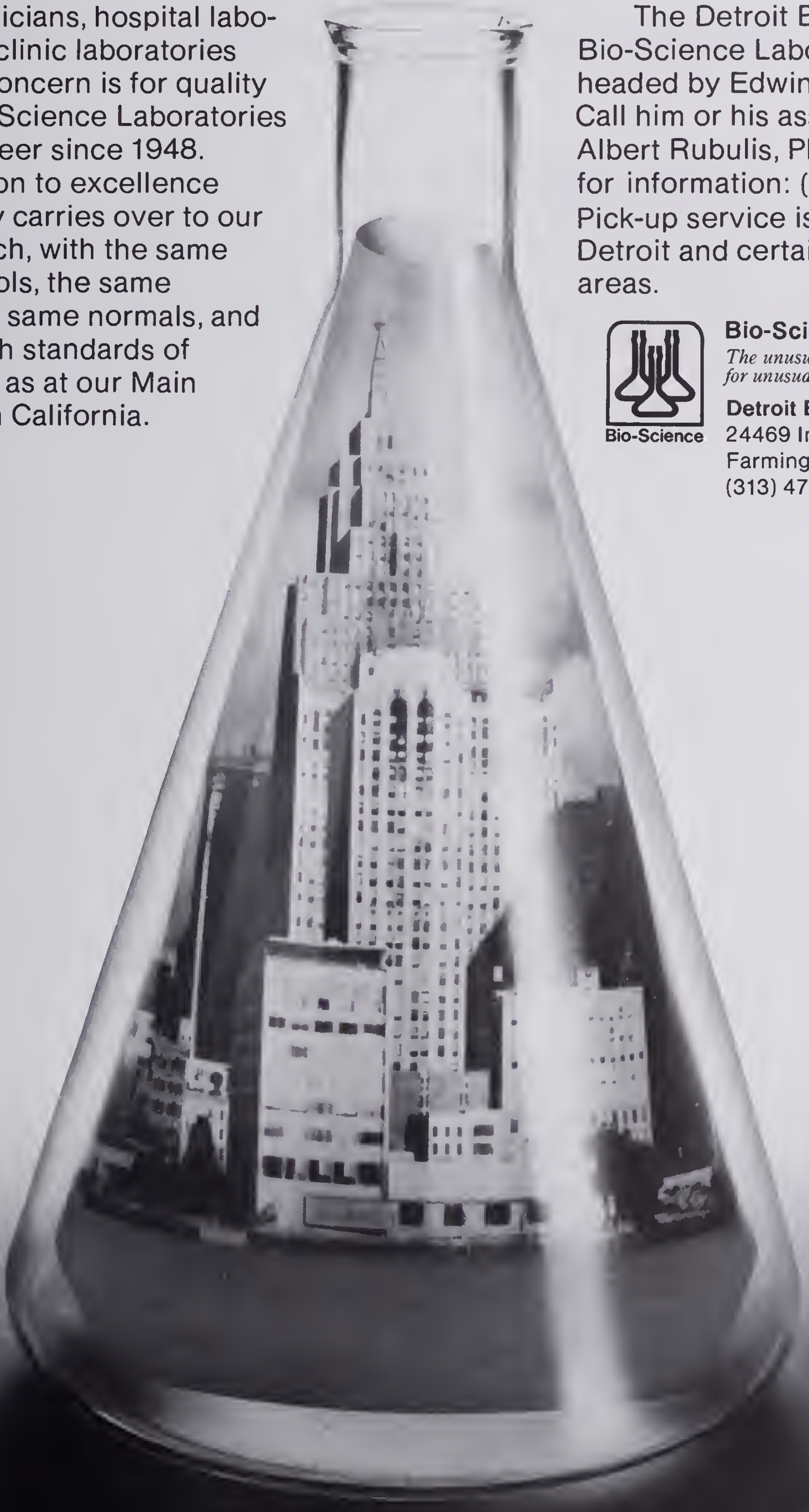

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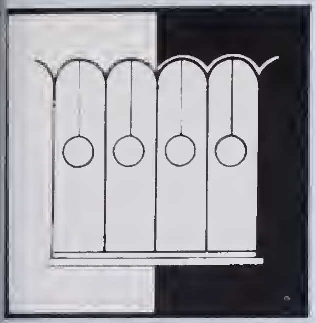


The reserve funds and fiscal management of MSMS

By Leland E. Holly, II, MD Muskegon

In 1968, the MSMS House of Delegates chose to mortgage the MSMS headquarters building in East Lansing, for $650,000 at 6¼% interest for 25 years. Principal retirement payments currently total approximately $18,000 per year. This is one "deficit" shouldered by our Society to achieve and continue three short-term objectives and to achieve one long-term objective.

Short-term Objectives

1. Spread the initial cost of the building over all generations of doctors who would benefit from it.
2. Provide for financial stability of MSMS while at the same time permitting the consideration and implementation of potentially costly programs and projects for Society members.
3. Take advantage of gains and interest income obtainable through prudent placement of mortgage and dues-realized dollars in deposit, bond and stock vehicles.

Concomitantly, a policy was adopted to fund the depreciation of the building and its major contents in part from revenues of the invested funds and in part from current membership dues. The share from each of these sources varied with fund performance. To date there has been no need to tap membership dues since the fund has provided the dollars required for repairs, replacements and structural depreciation.

Members of MSMS, through their dues, now pay for: 1) current society operations, 2) interest on the building mortgage, 3) principal payments on the mortgage, and 4) have a contingent dues responsibility to maintain reserve fund integrity.

Long-term objective

By continuing our present MSMS financial management principles and policy, somewhere around the year 1993 A.D. we will own our headquarters building free and clear and have at least $650,000 in reserves. At that time, the membership dues would no longer be used for mortgage principal and interest. MSMS would then have "arrived" as a fiscally stable and modestly strong organization. This was the long-term objective of the 1968 House of Delegates action.

Implementation

The Capital Protection and Capital Reserve Funds were established initially by the mortgage monies. The Capital Protection Fund has subsequently acquired the name of Creative Reserve Fund to better identify its purpose. A third natural fund segregation for dues and miscellaneous operational incomes has become known as the "Near Money" Fund.

The purposes, sources and restrictions on these funds have been formally set forth in the following "Fund Management Principles" formally adopted by The Council in 1975.

Near Money Fund

1. *Purpose* — Payment of current operational expenses.

2. *Source* — All usual and customary income from membership, dues, advertising, subscriptions, reprints, rents, interest on short-term investments.

3. *Maximum Amount* — Current fiscal year income including income from special assessments and excluding accrual from previous year's operations, plus a three-month operating reserve based on average monthly expense taken from prior year audit report.

4. *Investments* — Short-term, fixed-dollar, interest-bearing instruments with maturity staggered to meet operational needs, such as certificates of deposit, U.S. Treasury notes, high-grade commercial paper, bank acceptance, etc.

5. *Management Authority* — Finance Committee and The Council.

6. *Surplus* — Excess over maximum established in #3 above is to be automatically transferred to Capital Reserve Fund.

7. *Deficit* — A *potential deficit* is considered to exist when there is less than the maximum amount described in #3 above. Automatic review will be undertaken by the Finance Committee which may rec-

---

Doctor Holly is chairman, MSMS Finance Committee.

FISCAL MANAGEMENT / *Continued*

ommend specific corrective actions to The Council.

An *absolute deficit* is considered to exist when operating reserve falls below one month's average expense defined in #3 above and the Finance Committee must recommend corrective action to The Council. Such action may be among the following but may also be innovative:

A. Requesting House action to increase dues.

B. Transfer monies from other funds.

C. Borrowing money, or by other appropriate means.

Capital Reserve Fund

1. *Purpose* — Funding of depreciation for fixed assets — building, furnishings and equipment. Funding prospectively for a capital program approved by The Council and/or the House of Delegates. Funding for capital asset contingencies, emergencies, and operational contingencies or other emergency fiscal needs of the Society.

2. *Source* — Current balance; funding of prior year's audit report depreciation; market appreciation, dividends and interest of investments; and transfers from other funds.

3. *Maximum Amount* — Prior year's balance plus accumulated depreciation from prior year audit report plus an inflationary factor calculated yearly to reflect prior year's increase in appropriate Consumer Price Index, plus two months' current operating expense computed from average indicated in prior year audit report.

4. *Investment* — Minimum of one-third fixed dollar instruments with high yield, remainder in high grade stocks providing secure income and modest growth, such as "blue chip" listed stocks of the NYSE or ASE having large market penetration, e.g. utilities, established industrials.

5. *Management Authority* — Board of Managers and The Council.

6. *Surplus* — The value which exceeds the maximum amount guideline requirement #3 above by 15% is considered a surplus and may be transferred to Creative Reserve Fund annually by action of Board of Managers with approval of The Council.

7. *Deficit* — A *potential deficit* is considered to exist when the value of the fund is below that established in #3 above by the average of two months' operating expense computed from the prior year audit. Automatic review will be undertaken by the Board of Managers who may recommend specific corrective actions to The Council.

An *absolute deficit* is considered to exist when the value of the fund drops below the amount of the prior year's balance. An absolute deficit is also possible if, in addition to the above value, there is a special prospective capital funding program in arrears. The Board of Managers must recommend specific corrective action to the House of Delegates or, in its absence, The Council. These actions may be as follows but need not be limited to them:

A. Transfer of any surplus from the Operational Fund,

B. Increase in dues by House action, or

C. Transfer from Creative Reserve Fund with recommendation of Board of Managers and approval of The Council.

Creative Reserve Fund

1. *Purpose* — Provision of readily available funds for unexpected or special projects, grants, non-operational creative activities. Under conditions of unusual surplus, funds may be used for Council or House approved programs.

2. *Source* — Current balance plus fund appreciation through interest and dividends, appreciation/depreciation in market values, donations and transfers from other funds.

3. *Maximum Amount* — The amount considered desired in the fund will be related to the demands upon it and must be determined by the Board of Managers whenever necessary.

4. *Investment* — Growth-oriented common or preferred stocks with moderate yield. Approximately 10% of the fund should be in interest-bearing bonds or liquid equivalents.

5. *Management Authority* — Board of Managers and The Council.

6. *Surplus* — Presence of a

MSMS Financial Data

	Book Value 1968	Book Value 1969	Book Value 1976
Near Money Account (Operational Fund)	$125,741	$ 90,026	$ 537,800
Capital Reserve Fund	261,601	272,039	365,256
Creative Reserve (Capital Protection) Fund	382,767	382,473	348,475
TOTAL	$770,109	$744,538	$1,251,531
TOTAL ASSETS (includes building, etc.)	$1,390,969	$1,407,059	$1,967,249

	Market Value 1969	Market Value 1976
Near Money Account (Operation Fund)	$ 90,026	$ 537,800
Capital Reserve Fund	262,061	325,407
Creative Reserve (Capital Protection) Fund	322,414	285,385
TOTAL	$ 674,501	$1,148,592
TOTAL ASSETS (includes building, etc.)	$1,407,059	$2,388,000

surplus, like the amount of the fund as in #3 above, must be determined from time to time depending on fund demands compared to its value.

7. *Deficit* — When market value on investments and cash falls below $300,000, a *potential deficit* is considered to exist. When the total value is below $150,000, an *absolute deficit* is considered to exist. In each case, the Board of Managers may or must make recommendation for action to The Council in the same manner as with the Capital Reserve Fund. Deficits can be corrected by relatively short to near term stock appreciation** or contributions from individuals, other organizations or corporations. The Board may recommend other measures.

Performance

The payment of mortgage interest and principal from the Near Money (dues) Fund has spread the cost of our building annually among the current MSMS membership. Investment of dues in short-term, interest-bearing instruments has moved MSMS toward the long-range goal of building ownership and solid financial reserves.

That financial stability has been achieved is demonstrated by stability of dues in the face of large interim demands of building repair, furnishings replacement, expanded legislative programs, and the recent outlay of $205,800 for initiation of the MPMLC. While $186,000 of the latter has been repaid, all the costs were initially fully paid by MSMS without borrowing. Our reserve funds remain ready to support both planned and unexpected MSMS activities in the interests of our members without financial stress and in a manner which is effective.

It is the remaining short-term objective which appears to cause most concern among MSMS members. Conceived at a time of rising interest rates and a bull market, the plan to use short-term notes and higher interest deposit vehicles to generate income from the Near Money Fund and a conservative stocks and bonds program for Capital and Creative Reserve Funds' growth through appreciation and dividends appeared excellent.

In addition to subsequent poor market performance, its effect on MSMS reserve funds was magnified by poor choices of certain investments. The residuals of severe market losses are evident in our portfolio and its market value today in spite of significant gains in the last two years. The potential for this type of performance disappointment is inherent in the present financial management program and is accepted by MSMS financial managers. This is not to say that losses are accepted with a smile when they occur. Much effort is expended to avoid them.

The Near Money Fund fared much better through the recent years of high interest rates. Its performance was and is excellent although current interest rates are falling sharply at this time.

A second "deficit" has been questioned by the membership. This is the deficit which occurs on the MSMS books when budget or actual expense exceed prospective or actual income. Precisely because of the strong financial position of MSMS, these deficits can be accepted with equanimity particularly when careful budgeting and day-to-day financial management assures that every dollar is spent effectively in promoting the interests of MSMS membership. On the one hand, there is certainty that an over-spend will not break the Society, and on the other, the certainty that any over-spend is for good cause. More often than not, attention to financial management over a one or two year period can minimize or even wipe out these deficits. Furthermore, these are handled without borrowing and heretofore without dues increase.

Management is Dynamic, Representative and Reliable

The current low interest on short-term instruments is of concern. A desultory stock market promises nothing. Inflation continues. On the other hand, we continue to see the market value of our building and real estate climb. Better cost accounting has permitted clearer understanding of operational costs and has made possible increased personnel productivity and, as an additional benefit, provided opportunities for supplementing MSMS income in other areas. There is no steady state. Opportunities must be sought and pitfalls avoided.

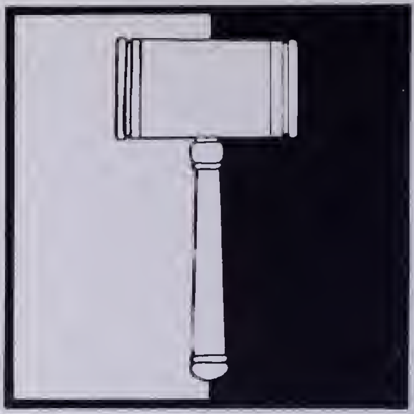
The MSMS Board of Managers, the Finance Committee of The Council, the Ways and Means Committee of the House of Delegates, and MSMS staff keep sharp watch and have MSMS objectives in mind at all times. Recommendations will be made if there comes a time when the implementation of MSMS objectives needs revision to maintain performance.

MSMS Fiscal Analysis

	Mortgage Balance	Interest Expense on Mortgage	Operating Fund Interest Income	Near Money Fund Balance	Book Value of Capital Reserve And Creative Reserve Funds [a]	Costs of Fund Administration
1968	$650,000	$ 9,255	$ 8,086	$ 758	$644,368	$ 900
1969	643,049	37,132	13,477	50,759	654,510	3,133
1970	630,529	39,836	18,466	146,991	655,726	1,200
1971	617,204	39,031	21,493	221,457	670,085	3,359
1972	603,021	38,174	22,241	230,200	684,771	4,531
1973	587,927	37,261	23,521	340,860	681,510	4,506
1974	571,861	36,290	44,622	384,882	668,623	4,282
1975	554,762	35,257	45,791	360,673	645,021	4,382
1976	536,536	34,130	30,412	537,800	713,731	4,188

[a] Excludes transfers, but includes dividend accumulation.

**"Short to near term stock appreciation" is limited to no longer than one year without re-evaluation and/or recommendation of methods for correction.



Revised public health code to be reintroduced

By Bruce Ambrose
Manager, MSMS Department of Government Relations

Thwarted in the last days of the 1976 Legislative session, sponsors of a revised Public Health Code will introduce the legislation again early in the 1977 session, which opened January 12. The Governor's State of the State message, delivered Jan. 13, indicated some of the trends in government-and-medicine for the next two years.

Governor Milliken promised further legislation, if needed, to continue alleviation of the medical malpractice problem, and he placed the decision on Insurance Commissioner Thomas Jones. He said, "I am directing the insurance commissioner to report to me and the Legislature by this spring on the effectiveness of the 1975 package of reforms, the access to and price of liability coverage, and steps that should be taken to ease the problems that persist."

The Governor added that consideration shall be given to "reconstitution, modification or expansion of the Brown-McNeely Fund, which expires in the summer of 1977."

On Medicaid problems, Governor Milliken declared, "We will not permit needless and unjustified expansion of services which could lead to destruction of the entire Medicaid program." He cast the problems of Medicaid within the entire structure of welfare problems, saying, "I am determined that the welfare system will be straightened out and operated openly and honestly."

He said he will recommend legislation early in the new legislative session to establish better controls of Medicaid, and that he will seek to create a task force of consumers, providers and legislators to develop appropriate cost containment measures.

He also gave high priority to the proposed new public health code.

Perhaps highest in priority, at least first on the calendar, will be the 1977 version of PHSRP. Few changes are anticipated from the 1976 proposal, and the battle is expected to center again on licensure of health professions. There is some sympathy for the position that, should the total package run into difficulty, the licensure section may be deleted in order to pass the remainder.

Of mounting importance to the Medical Practice Board is a requirement that two members of the board participate in all hearings. This requirement is beginning to overburden the 10 physicians on the board, and some legislation to alleviate that problem can be expected.

A task force has been working for some time on a "living will" type of legislation, and sometime in the two-year session legislation to that end may be anticipated. Progress remains in the early stages, however.

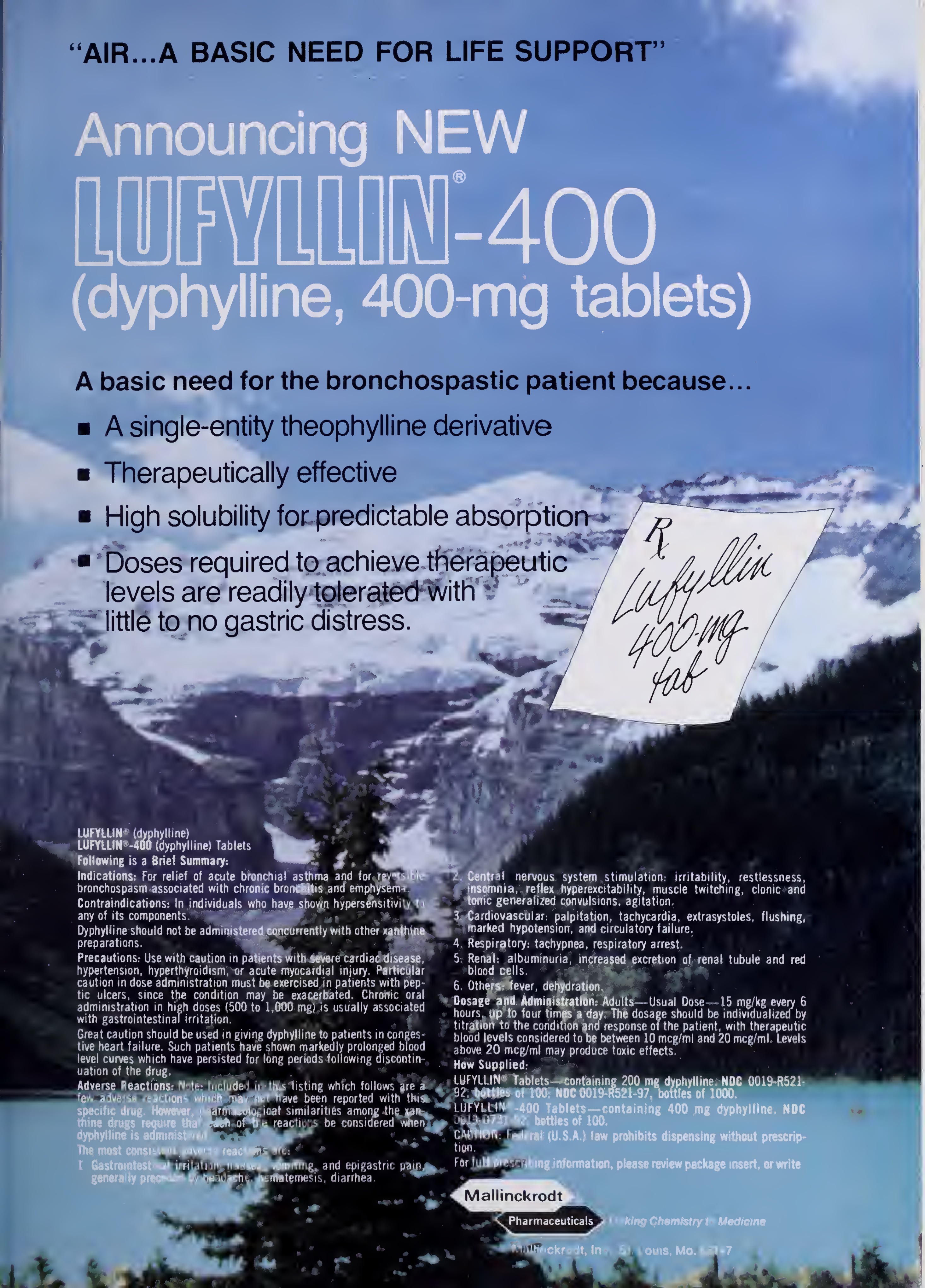
The MSMS malpractice package, including an amendment in the continuing medical education statute to move to a 150-hour, three-year-cycle, will be introduced early in the session.

Physicians' views of malpractice cases off-base?

In an exhaustive study of medical malpractice litigation, the National Center for Health Services Research of the Department of Health, Education and Welfare has published the following findings: (1) Few attorneys actually specialize in medical malpractice litigation, (2) Plaintiffs' attorneys are an important vehicle for "screening out" malpractice claims, (3) The "contingent fee" system tends to result in rejection of some meritorious claims, because they are not economically feasible to pursue. It does not seem to encourage pursuit of non-meritorious claims where possible damages are high, but potential for recovery is quite low, (4) Malpractice cases take more preparative and investigative hours than any other personal injury cases, (5) Juries generally understand the medical issues in a malpractice case, and (6) Juries generally understand, though to a lesser degree, the legal issues in a malpractice case.

It is noted in the study that all of the findings directly contradict the widely held beliefs of the medical profession with regard to medical malpractice.

— The Michigan
Hospital Association
Monday Report



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Dyphylline should not be administered concurrently with other xanthine preparations.

Precautions: Use with caution in patients with severe cardiac disease, hypertension, hyperthyroidism, or acute myocardial injury. Particular caution in dose administration must be exercised in patients with peptic ulcers, since the condition may be exacerbated. Chronic oral administration in high doses (500 to 1,000 mg) is usually associated with gastrointestinal irritation.

Great caution should be used in giving dyphylline to patients in congestive heart failure. Such patients have shown markedly prolonged blood level curves which have persisted for long periods following discontinuation of the drug.

Adverse Reactions: Note: Included in this listing which follows are a few adverse reactions which may not have been reported with this specific drug. However, pharmacological similarities among the xanthine drugs require that each of the reactions be considered when dyphylline is administered.

The most consistent adverse reactions are:

1. Gastrointestinal irritation: nausea, vomiting, and epigastric pain, generally preceded by headache; hematemesis, diarrhea.
2. Central nervous system stimulation: irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions, agitation.
3. Cardiovascular: palpitation, tachycardia, extrasystoles, flushing, marked hypotension, and circulatory failure.
4. Respiratory: tachypnea, respiratory arrest.
5. Renal: albuminuria, increased excretion of renal tubule and red blood cells.
6. Others: fever, dehydration.

Dosage and Administration: Adults—Usual Dose—15 mg/kg every 6 hours, up to four times a day. The dosage should be individualized by titration to the condition and response of the patient, with therapeutic blood levels considered to be between 10 mcg/ml and 20 mcg/ml. Levels above 20 mcg/ml may produce toxic effects.

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". . . we are attempting to accumulate data re: so-called religious cults . . ."

For a statistical research purpose, we are attempting to accumulate data regarding the number of physicians, and other professional men in this country, who have had, or still have, members of their families involved with the so-called religious cults such as:

1) Occult — Witchcraft and Satan Cults (Druids, etc.)

2) Vedic Hindu such as Hare Krishna, Divine Light Mission, etc.

3) Christian based — Unification Church ("Moons"), Church of the Bible Understanding (Forever Family), The Way, etc.

4) Political — The Weathermen, National Social Labor Coalition, etc.

5) Pseudo Scientific — Scientology, UFO, The Foundation (The Process).

6) Other

Inasmuch as there is a question of hypnosis being used by the cults, and also some questions regarding the health and well-being of members involved in cults, I would appreciate your cooperation.

We would also be interested in hearing from, or hearing about, any physician who is, or has been, a member of such a cult.

Interested persons should reply to:

John G. McConahy, M.D.
Individual Freedom Foundation
143 Valhalla Drive
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Thanks for providing information that I requested about the Tel-Med project sponsored by the Wayne County Medical Society and Blue Cross/Blue Shield of Michigan.

I will provide the Tel-Med brochure to all my constituents who write me and ask for it. My current *On Target* newsletter offers the brochure, with the following descriptive copy:

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State Senator David Plawecki
Twelfth District

". . . stop accusing physicians for lack of concern over cost control . . ."

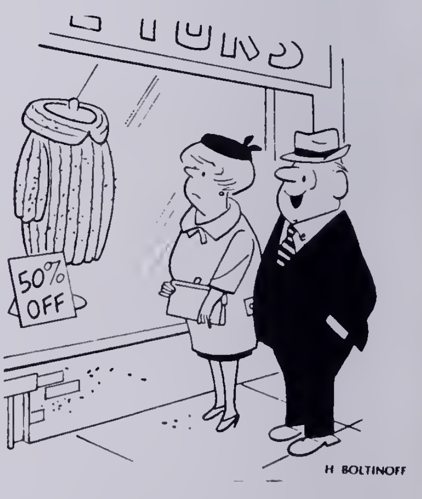
I must take violent exception to Dr. Marion G. McCall, Jr.'s criticism of physicians in his "mini-editorial" in the December 20, 1976 issue of *Medigram*. Here he condemns physicians for admitting patients to hospitals on week-ends and accuses us of lack of concern over cost control.

If hospital unions, civil service administrators, and others concerned with cost control would recognize that medical illness is a twenty-four hour a day/seven day a week problem and not an 8-5/Monday-Friday business, then hospitals would run at full steam on week-ends as well as during the week. Thus, patients could be admitted — and served properly — in hospitals seven days a week. Expensive equipment like radiology and clinical pathology laboratories offer *minimal* service for 16 hours of the day. Thus, patients are kept in hospitals for several additional days awaiting scheduling of procedures.

This could go on and on, but I think it is time that the Michigan State Medical Society, and physicians in general, stop accusing physicians for lack of concern with cost control when, for years, we have proposed more efficient operation of expensive health care facilities such as hospitals.

If hospitals and their employee unions insist on operating only five days a week, I refuse to take the blame for the increased cost to the public resulting from their irresponsible attitudes, not only in terms of cost control but in terms of the public welfare in general.

Very truly yours,
Mark C. Levine, M.D.
Flint



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Possibly Effective:
1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

omposition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
asodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

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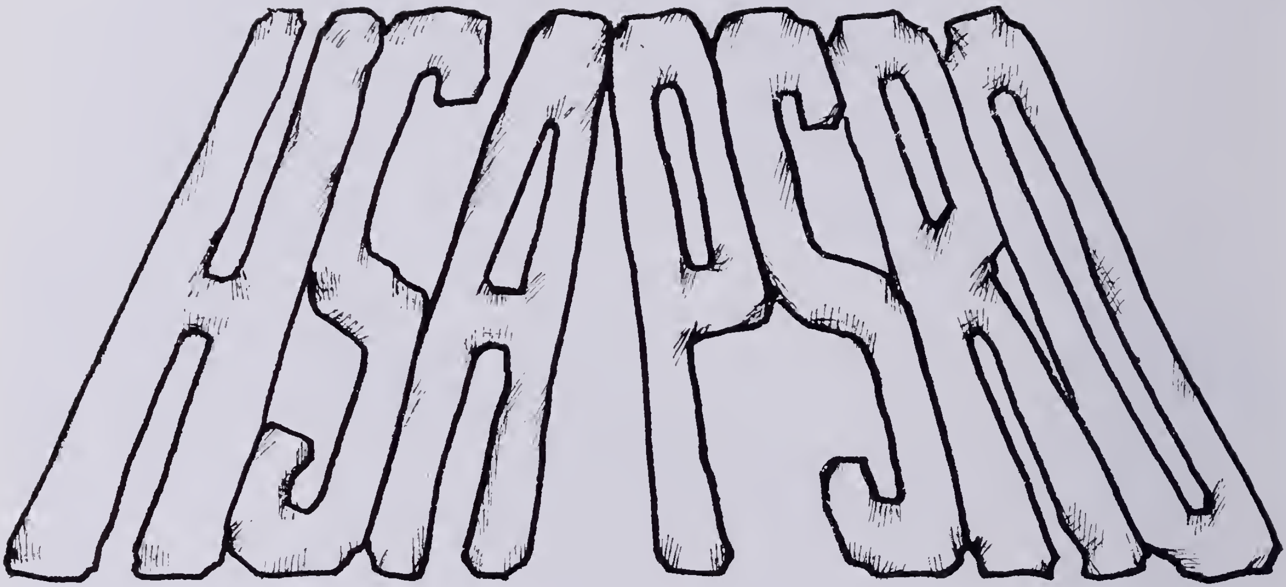

It's time to think about relationship between PSROs and HSAs

By Judith Marr
Managing Editor

Michigan physicians have many questions about new health care planning and regulation systems in Michigan.

Particularly confusing is the relationship between Professional Standards Review Organizations (PSROs) and the newer Health Systems Agencies (HSAs).

(1) What is the status of PSROs in Michigan?

(2) How far along are HSAs in their development?

(3) Do the two overlap and duplicate activities, and how will they work together?

This article will attempt to answer those three questions.

1. There are 10 PSRO areas in Michigan. They were mandated by the Social Security Amendments of 1972 to carry out local peer review of services provided under federal health care programs. PSROs are to be made up of doctors of medicine and osteopathy only and are to serve as a powerful provider force for the assurance of quality health care.

To date there are two PSROs in Michigan which have advanced through the planning stage to the conditional stage, as designated by

HEW. They are Area I — Upper Peninsula, and Area V — Genesee, Lapeer, Shiawassee counties. State PSRO officials predict that a third — Area VIII or Wayne County — PSRO will become conditional by late spring. They expected another five of the areas to be awarded planning funds by HEW by March 1. There is no activity toward formation of a PSRO in Area II, and doctors in Area IX are waiting until July when they will meet to decide what action they may take.

When there are three conditional — functioning — PSROs in Michigan, a State Professional Standards Review Council will be appointed by HEW.

The Council is to consist of one representative from each of the conditional PSROs, and one each from MSMS, the Michigan Association of Osteopathic Physicians and Surgeons, the Michigan Hospital Association and consumer groups. Eventually, when all 10 PSROs are conditional, the Council will have 18 members.

2. Since the advent of the PSROs, eight Health Service Areas, each with its own Health Systems Agency, have been designated in Michigan. HSAs were created by PL 93-641, the National Health Planning and Resource Development Act of 1974.

HSA governing boards are to be comprised of a consumer majority not to exceed 60%, with the remainder to be made up of providers, not less than ⅓ of them physicians. To date, there are approximately 25 Michigan physicians on HSA boards around the state.

A Statewide Health Coordinating Council oversees the activities of all the areas and agencies. Physicians serving on the Council, appointed by Governor Milliken, are D. Bonta Hiscoe, MD, Lansing; Andrew D. Hunt, Jr., MD, East Lansing; Robert S. Libke, MD, Gaylord; Maurice S. Reizen, MD, Lansing; Donald C. Smith, MD, Lansing; James F. Tobin, Jr., MD, Ishpeming; Robert J. Toteff, MD, Saginaw, and Ian D. Wilson, MD, Petoskey.

3. How will PSROs and HSAs work simultaneously?

"That's the hooker," declares Michigan PSRO Support Center Director Herbert Mehler, East Lansing. "Ideally the HSA and PSRO need to work together if a health system plan is to reflect medical opinions. But it's going to be a serious problem."

"Cooperation between the two depends upon how sensitive they are to each other's needs," says Jay Endsley, director, Office of Health and Medical Affairs. OHMA now is the state health planning development agency. Mr. Endsley also staffs the SHCC.

PSRO/HSA interface

All groups involved, including MSMS, currently are working hard to think out ways in which PSROs and HSAs can cooperate to ensure quality health care and avoid ending as adversaries.

PSROs and HSAs both intervene in the current process of providing and purchasing medical care. They have been established under federal law to regulate the supply and use of medical care resources.

However, notes a recent University of California Medical School study, "HSAs and PSROs are intervening on opposite sides of the same market — the supply and demand for medical care resources.

"HSA legislation identifies three related kinds of supply problems," the study continues. "These are (1) shortages and surpluses of resources, (2) the wrong mix of services and (3) the inefficient use of resources. The new law contemplates that HSAs will deal with these problems by controlling facilities' expansion and entry into the market, by reviewing and approving the use of federal health care grant dollars, and by planning for and encouraging a more rational use of community resources.

"The PSRO intervention is on the paying side — or in economists' terms, the demand side. PSROs will influence the demand for medical care services by determining criteria upon which use of services should be based — how many days of hospitalization, in what kinds of facilities, and in what circumstances. PSROs will use these criteria to review and monitor the actual use of hospitals and other resources. Ultimately, the strategy is for the federal government to refuse to pay the bill unless a PSRO says the care is 'necessary and appropriate.' "

Memoranda detail cooperation

In March, 1976, the *Federal Register* printed memoranda of understanding which detail the ways in which HSAs are expected to work with PSROs.

The *Federal Register* declared that the two are to share data and information such as statistics on patterns of utilization and quality of care subject to the PSRO confidentiality policy restrictions. (PSROs are not to give out any information identifying specific providers or hospitals.)

The PSRO is to review and comment on the HSA's health system plan (HSP) and annual implementation plan (AIP); the criteria adopted by the HSA for reviews of proposed health system changes, especially with respect to quality of care; use of services and facilities and the need for new resources.

The HSA is to make technical assistance to the PSRO and the PSRO is to assist the agency especially in developing the HSP, AIP and the criteria for review of proposed health system changes.

Actions taken by the PSRO which alter the area's health system are to be made consistent with the HSP and the AIP in effect for the area.

"One of the major problems, however," says Mr. Mehler, "is that no memoranda of understanding have been issued describing how PSROs can work with HSAs. This will remain a problem until HEW clearly defines what PSROs can and cannot give to HSAs in the way of statistical breakdowns and identification of problems." (PSRO confidentiality requirements now are in limbo, he says, while PSRO and HSA officials can agree on how to work with them.)

"I expect federal regulations will remedy this situation soon," says Mr. Endsley, "at least to allow institution-specific data to be shared."

The recent UC School of Medicine Health Policy Program study of potential HSA and PSRO cooperation notes:

"While the agencies are being established as independent entities, their decisions and actions are certain to affect each other. Because the collective impact of both on medical care may well differ depending on their relationship with each other, the potential HSA-PSRO interactions are worth considering now."

How to work together

The California study concluded that the greatest potential for operational inputs is from the PSRO to the HSA.

HSAs and PSROs might cooperate in two primary areas, the study found. The first would be in activities in which the agencies would inevitably affect each other; principally where, for example, the review activities of the HSA will have an impact on PSRO review of the quality and need for care, and vice versa.

The second would be in the flow of information generated by the PSRO and the HSA. The exchange of data is a key area of potential conflict in many experts' eyes.

The law creating HSAs demands that HSAs enter agreements with PSROs for purposes of data exchange. HSAs are required to obtain needed information from other available sources, specifically cooperative health statistics systems, rather than generate their own data.

PSROs, on the other hand, began with strict regulations governing the confidentiality of data. All groups wish to avoid duplicating their information-gathering efforts, yet at the same time gain the maximum power. This complication of conflicting requirements and political maneuvering are what physicians need to know about in order to insure that quality health care is the final result of PSRO and HSA activity.

A good example is the current debate in Michigan as to whether PSROs should share data with HSAs directly, or with the Michigan Cooperative Health Information Systems (MCHIS), which in turn would share the data with HSAs.

If PSROs give data directly to the MCHIS, they simplify their work; cut the budget for the MCHIS, as the data probably would be provided free of charge, yet lose chances to influence HSAs activities.

The struggle, if one develops, is still ahead, as PSROs are not formed in Michigan and the rules and regulations for HSAs are yet to be formalized. But physicians should be aware of what's ahead, to be able to seize the initiative.

At a recent AMA Medical Society executive conference on health planning, seminar leaders emphasized that physicians must be asking: What type of data will the HSAs need from the PSROs and in what form? How will this data be aggregated and interpreted? How will confidentiality be maintained? What will happen if PSROs choose not to cooperate?

"The questions are many and the answers few," read seminar materials.

Some suggestions

Among the first to offer some answers is the California Medical School study. In preliminaries it said: "Our broad finding is that the two agencies can and should work together in some instances, particularly in the sharing of data, but that their interests diverge too greatly to make such cooperation generally possible or desirable in a number of other respects."

The study refers to "a basic conflict — the orientation of planning agencies toward the community and the orientation of PSROs and their member physicians toward individual patients."

"Where the agencies can and should cooperate, there are benefits to both," the study says. "The HSAs need medical expertise and objective information. For physicians the relationship offers a means of assuring that planning decisions that affect medical practice are made on the basis of accurate information."

The study recommended, among other things, that HSAs solicit the views of the PSRO on the impact of HSA decisions on the quality of care, that PSROs participate in certain aspects of the decision-making of HSA, that each agency attempt to get the cooperation of the other when some action is required to make its work effective.

The HSA should try to work out cooperative arrangements with the PSRO to obtain information valuable for planning purposes, the U-C study said. But HSAs and PSROs should not be forced at this time to work together, as the situation is too uncertain for both.

Problems of cooperation between HSAs and PSROs can be resolved, Mr. Mehler predicts, if the responsibilities of both are clearly defined and both groups do not breach those definitions.

Cooperation between PSROs and HSAs is more a problem of time, says Mr. Endsley. "Both have tremendous responsibilities, but the level of funding is insufficient for them to accomplish even basic responsibilities. It'll become a lack of staff time, not interest.

"If they could intermingle their boards some, it would be helpful. Even if providers could get some joint appointments, there would be some chance of people raising questions of how the two agencies could work together."

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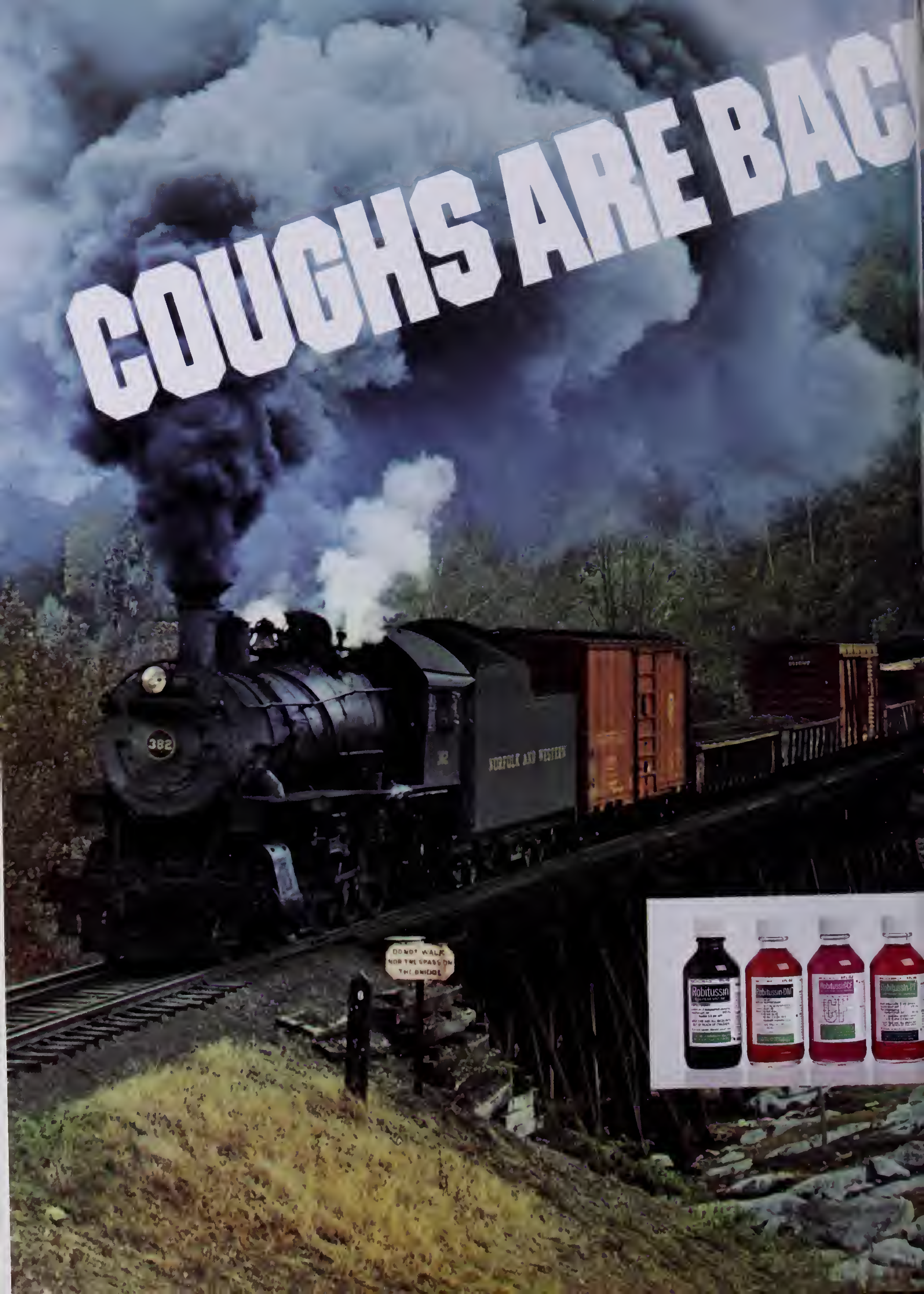
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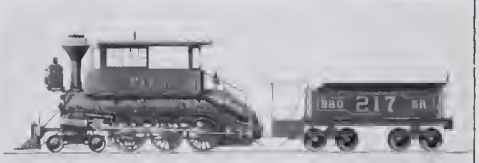

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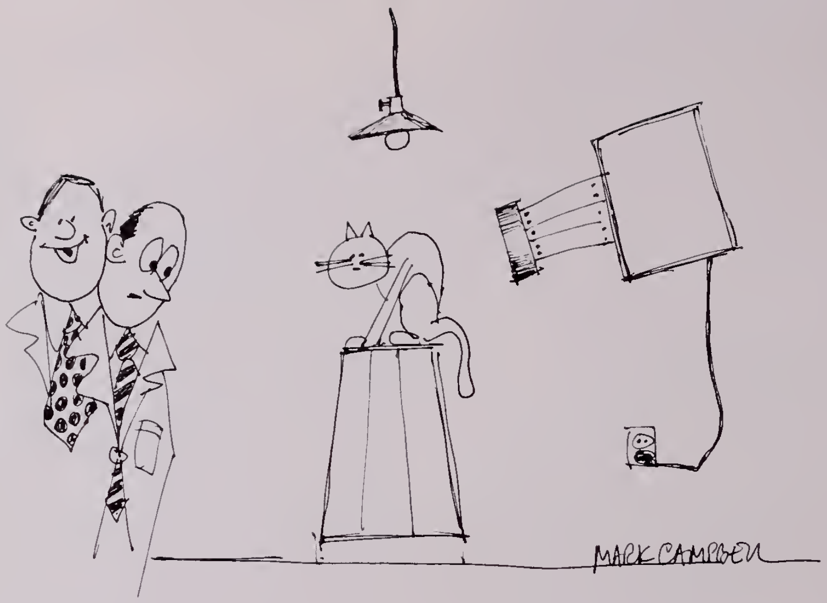

"We wanted to be the first C.A.T. Scanners in Michigan."

The CAT Scanner controversy – some views

By C. R. Shelton
Special to Michigan Medicine

X-ray scanners employing a noninvasive process called computed tomography (CT), or computerized axial tomography (CAT), apparently have opened a new era of diagnostic medicine.

Physicians justifiably desire using the new process as a new and effective tool, and patients are even beginning to request the scans.

At the same time, costs associated with the scanners have created vigorous opposition to their use from some who fear that indiscriminate purchase and use of the expensive equipment will greatly increase the cost of health care.

Basically, there are two types of CAT scanners: those that scan the head, and those that scan the whole body.

According to one scientist, in most CAT scanners, a narrow-beam X-ray projector/detector device is combined with a computer to record the coefficient of X-ray absorption by each different part of the brain. The computer then gives a digital read-out of the density of each of the brain's parts. This read-out is transduced into a three-dimensional picture of a cross section of the brain.

What an observer actually sees is a video representation of a mathematical process. However, from a practical point of view, he or she sees a television picture of the inside of living body substance. The video image can be studied immediately or taped for later scrutiny.

CAT scanners first were introduced in 1972 by an English firm. Now about 12 U.S. companies are either producing or developing CAT equipment. Approximately 800 scanners have been sold throughout the world, and over 600 are in use. According to information from Michigan's Department of Public Health, 19 have been approved to date for the state, but only 11 are in operation.

This impressive acceptance by the medical community and by patients is completely justified, states one noted physician. He says that scans reveal with astonishing clarity details previously seen only in autopsies.

But the scanners cost between $350,000 and $600,000, and at some point the initial cost of the equipment plus costs associated with performing scans, will have to be borne by patients and/or third party payers.

Cost causes concern

Fears that these costs will amount to millions of extra health care dollars per year have caused government officials, health planners, and insurers to ask probing questions about CAT scanners and to place controls on the numbers approved for use.

Some of these groups are concerned about the capitalization cost for the equipment, individual charges for CAT scans, and cost effectiveness of CATs in eliminating other diagnostic studies or reducing hospitalization expenses.

Nationwide decisions to allow CAT scanners in hospitals — paid for by federal funds — are based on the So-

(Continued on page 72)

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* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg in bottles of 60, 250. Rx only.

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cial Security Act, section 1122, and for all other monies, on state Certificate of Need Laws.

The Social Security Act's purpose is to assure that federal funds are not used to support unnecessary capital expenditures for health care facilities. Under the section noted above, each state must have a designated planning agency to review all capital proposals in excess of $100,000 and submit recommendations to the Secretary of the Department of Health, Education and Welfare. The law further states that the Secretary will withold reimbursement from institutions that fail to file the required Statement of Need. The criteria which the designated planning agency uses in evaluating proposals include: current or projected community need for health services; prospects of adequate staffing and operation; economic feasibility; and cost containment through productivity.

Since CAT scanner prices are well in excess of $100,000, approval of planning bodies — in Michigan these are the eight Health Service Agencies and the Michigan Department of Public Health — is a requirement for acquisition of the scanners.

A large number of requests, by providers, have been made for CAT scanners in Michigan.

Michigan rules for CAT scans

The MDPH, which has the authority to approve Certificates of Need (approval is necessary before CAT scanners may be purchased by hospitals) has stated the following policy:

- The applicant hospital or health facility must be located in an area that has a projected 1980 regional population of at least 600,000;
- CAT scanners are slated in regional base centers as follows: two scanners for the Marquette-Petoskey-Traverse City area; three for Bay City-Saginaw; three for Grand Rapids-Muskegon; three for Kalamazoo-Battle Creek-Benton Harbor-St. Joseph; three for Lansing-Jackson; two for Flint; and 16 for the area encompassing Ann Arbor, central Detroit, northwest Detroit-Pontiac, northeast Detroit-Mt. Clemens-Port Huron, and Wayne-Dearborn-Wyandotte;
- Although CAT scanners have been programmed for the above centers, any application for such equipment will be reviewed in terms of consistency with standards, criteria, and policies developed by the local HSA and by the state agency, with consideration given to the availability, accessibility, and utilization experience of existing services and facilities at the time of application. Consideration for CAT scanners above the stated level will be given only upon clear evidence that current scanners in the region are being effectively and appropriately utilized, and only insofar as the applicant substantially meets the policy requirements;
- Applicants under State Act 256 and/or Section 1122 are to consult with their local HSA concerning applications. The Michigan Department of Public Health gives HSAs the option of reducing the number of scanners in their areas and the determination of whether scanners in physicians' offices are to be included in the area's total allocation.

Planning organizations have no authority to prevent private physicians from buying CAT scanners. However, third party payers will not pay for scans unless made on government-approved equipment.

Further limits on the use of CAT scanners in Michigan are affected because Blue Cross-Blue Shield of Michigan, Medicaid and Medicare presently will pay only for scans of the head, not for body scans.

Radiologists decry restrictions

The Michigan Radiological Society's Ad Hoc Committee on CAT scanners reported in June, 1976 that "Computed Tomography is a valid and important new modality in diagnostic radiology. It is a useful and highly effective diagnostic method supported by an impressive body of international scientific literature, knowledge, and experience. CT is the most effective tool in neuroradiology. It should be readily available to inpatients and outpatients. CT alone is safe and noninvasive . . . CT is very helpful in diagnosis of acute head trauma, for detection of intracerebral, subdural, and epidural hemorrhage. CT is now considered the most essential method of intracranial diagnosis but it will not immediately replace all other methods . . .

". . . CT of the thorax and abdomen is clinically significant . . .

". . . Definite delay in the advancement of body scanning techniques has resulted from confusing restrictions imposed by health planning councils . . . The rapid accumulation of knowledge and subsequent transfer to clinical application in Michigan has been delayed. It is incredible that legislation intended to improve the health care of our country has served to delay, or prevent entirely, the availability of important diagnostic tools. . .

"A modern comprehensive hospital radiology department is a proper site for a CT unit. Certain specialized institutions such as radiation therapy centers and pediatric hospitals may also be proper locations. The well equipped modern radiology office under the regular adequate supervision of a properly trained radiologist could also be the site of a CT unit . . .

". . . CT appears to be cost-effective."

Albert A. MacPhail, MD, chairman of the Michigan Radiological Society's Ad Hoc Committee for CAT, and chairman of the Department of Radiology, St. Joseph Hospital, Flint, states that "the scientific community has its own system of controls and in the past this has worked well. When a new test or procedure was developed through research and was validated, results were disseminated to the community and those procedures or tests that were effective became a part of good medical practice, while those that were not were discarded.

"Never before have government officials, and others, attempted to impose cost effectiveness on possibly life-saving methods of diagnosis.

". . . If all the work, time, talent and effort that have gone into applying for CAT scanners were added up, the totals would probably come to enough to buy many scanners for the state.

"Rigid government controls based on the amount of money some important new diagnostic equipment costs is ludicrous. In the long run, these controls on CAT scanners will not prove to be of benefit to mankind."

Doctor MacPhail suggests that what the medical community needs now is for someone with a good medical background to study existing laws plus the constant changes being made in regulations, and to quickly disseminate this to physicians.

"We cannot make optimum progress now under all the controls that are on us, unless we fully understand what is required by law."

Blues have reservations

Blue Cross-Blue Shield of Michigan Group Vice President of Professional Affairs, Louis F. Hayes, MD, states that the Blues received the first claims for CAT scans about two-and-one-half years ago when there were only two scanners in the area. An average payment per scan then was $220. In late 1975 when American manufacturers entered the CAT field in earnest, the Blues began to receive inquiries from hospitals asking if the insurer would pay for CAT scans.

The firm became concerned about the possibility that an unlimited number of CAT scanners, used sufficiently to make the purchase of the machines profitable, could lead to millions of claims.

Their main concerns regarding CAT scanners are: costs, inappropriate (possibly over) use of scans, allocation of resources, and maximum productivity of the machines.

"No one questions that CAT scans are highly successful and safe in determining if there is a neurological disorder in the brain, but body scans have yet to be proven as successful," says Doctor Hayes. "There needs to be some sort of an agreement among physicians, patients and third party payers on when it is appropriate to use CAT scanners."

Doctor Hayes cites one definitive study which showed that scans do not lead to earlier surgery for brain tumors, and there is no less morbidity in the surgery that is performed.

"Definitely a scan can help a doctor diagnose more accurately, quickly,

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CAT SCANNER / *Continued*

and with less pain to the patient, but after the diagnosis the scan changes little."

The Blues' position is that CAT scanners should be controlled, that there should be sufficient numbers of them for needed diagnosis, but that they should not be allowed to be purchased in such quantities that they lead to unnecessary screening.

"Every institution that has a CAT scanner should be a community resource, allowing as many patients as possible to be scanned by the same equipment. This equipment should be in operation for as many hours as possible during a 24-hour period, so that no one could justifiably say that they are barred from use of the scanners.

"The best way to assure the lowest cost to patients is to make maximum use of a few scanners, not just a little use of many."

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Doctor Hayes emphasizes that concern about CAT scanners is national. The Blue Cross Association has requested the National Academy of Sciences' Institute of Medicine to study the new technology, and to propose recommendations for policy allocation and reimbursement. The first committee meeting was held in late December.

Responding to the question of when there may be a change of policy regarding payment for body scans since so many believe such scans can be a useful diagnostic tool, he stated that perhaps a decision would be made within the next six months.

Concerning the number of scanners that should be in use outside of hospitals, Doctor Hayes suggests that, "the medical association should take the responsibility for allocating CAT scanners in the private sector, and not let it go by default to others as has happened with hospitals."

CAT scan problem harbinger

James D. Fryfogle, MD, vice president, Southeast Michigan Health Service Agency; chairman, Board of Trustees, Wayne County Medical Society; Speaker of the Michigan State Medical Society's House of Delegates, and medical staff member at Providence and Mt. Carmel Hospitals, Detroit, states that government actions regarding CAT scanners are interfering with the development of an important, new diagnostic technique.

"One of the major problems in medicine today is that the government promises first class care, but insists on paying economy fare.

"Cost containment definitely should be a factor in CAT scanner planning, but it looks as if we are not being allowed to make initial investments that can save a great deal of money in the long run.

"The state of CAT scanning art has not developed to the degree that we can see its real value in comparison with older, more accepted methods of diagnosis. However, the CAT scanners open up a whole new vista of diagnostic possibilities that may save the patient from the pain of invasive diagnosis and that may allow therapeutic techniques that are life-saving to be instituted at an earlier date.

"As familiarity with total body scanning develops, many of the current diagnostic techniques — which are expensive — will be discarded. This will create savings and also will give a greater diagnostic acuity without pain or discomfort to the patient.

"At this time, no one knows exactly how many CAT scanners are necessary, and we won't know until CATs have been used to the point that they become a standard part of a patient's work up. When that occurs, costs will fall and CATs will be tools that are used as required, not special things that are saved for certain unusual circumstances."

Doctor Fryfogle believes that at the very least, every hospital with a competent radiological department should have CAT scanners to perform necessary diagnoses.

"The patient who is not privileged to have a scan, if his physician orders one, is not getting good medicine, and we may see law suits result from such lack.

"Health Service Agencies should promote the new CAT technique — under controls if it must be — so that we can get definitive case studies as quickly as possible to prove, or disprove, the scanners' real place in medicine.

"I would agree that organized medicine should work through the accepted federal planning process. I think that the medical portion of the decisions made by these agencies should be the voice of the doctor. Cooperation of all parties concerned with this problem should be the goal of our efforts.

"The problem with CAT scanners is a single one. There will be other diagnostic equipment, other methods of delivery of care, and other innovative techniques as we progress. How we handle this problem will be important in future health decisions."

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Meetings

(See also listing of Category I programs on page 91)

March/77 — Symposium on Applied Psychoanalysis, contact: Michigan Psychoanalytic Soc., 16310 West 12 Mile Road, Southfield, Michigan 48076.

March 2 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director.

March 9 — Regular meeting, Michigan Dermatological Society, at University of Michigan, Ann Arbor, contact: Richard F. Elton, MD, 15901 West Nine Mile Road, Southfield, Michigan 48075.

March 14-18 — Seminar, Advanced Techniques for the Health Record Analyst, Ann Arbor, Michigan, contact: Commission on Professional and Hospital Activities, 1968 Green Road, P.O. Box 1809, Ann Arbor, Michigan 48106.

March 21-25 — Seminar, Hematology for Medical Technologists, contact: University of Michigan Medical Center, Dept. of Postgraduate Medicine and Health Prof. Ed., Towsley Center for CME, Ann Arbor, Michigan 48109.

April 14-17 — Annual Meeting, State of Michigan Branch, American Association of Medical Assistants, Kalamazoo Civic Center, Kalamazoo, contact: Mrs. Ginger Hyatt, Chairman, 2533 Cumberland St., Kalamazoo 49007.

April 19-21 — International Symposium, "Human Ovulation," at C. S. Mott Center for Human Growth and Development, Wayne State University School of Medicine, Detroit, contact: E. S. E. Hafez, MD, C. S. Mott Center.

April 20 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, director.

April 27 — Legislative Day, MSMS Auxiliary, at Olds Plaza Hotel, Lansing, contact: Helen Schulte, MSMS Headquarters.

May 2-4 — 51st Annual Convention, MSMS Auxiliary, Troy Hilton, Troy, contact: 272 Ashland Avenue, Detroit 48215.

May 6 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director.

May 13-15 — 1977 Annual Session, MSMS House of Delegates, Troy Hilton, Troy, contact: Richard Campau, MSMS Headquarters.

May 14 — May Seminar, "Lymphoreticular Disorders," Michigan Society of Pathologists, at Hurley Hospital, Flint, contact: Jacob E. Briski, MD, Saint John Hospital, 22101 Moross Road, Detroit 48236.

May 16-27 — Seminar, Health and Chronic Disease among the Elderly, Arts and Architecture Building, U of M, Ann Arbor, contact: Dorothy H. Coons, Director of Cont. Ed., The Institute of Gerontology, The University of Michigan-Wayne State University, 520 East Liberty, Ann Arbor, Michigan 48109.

May 24-27 — Annual Meeting, Michigan Public Health Association, Park Place Motor Inn, Traverse City, Michigan, contact: MPHA 484-3044 or James K. Edmunds, (313) 557-1400.

May 31-June 13 – MSMS/INTRAV Alps/Riviera Adventure, contact: Mrs. Marcelyn Ireland, MSMS headquarters.

June 13-17 — Seminar, Speech, Language and Hearing Problems of Older Persons: Identification and Management, Arts and Architecture Building, U of M, Ann Arbor, contact: Dorothy H. Coons, Director of Cont. Ed., The Institute of Gerontology, The University of Michigan-Wayne State University, 520 East Liberty, Ann Arbor, Michigan 48109.

June 15 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director.

June 18-22 — AMA Annual Convention, San Francisco.

July 11-22 — Seminar, Biology of Aging, Arts and Architecture Building, U of M, Ann Arbor, contact: Dorothy H. Coons, Director of Cont. Ed., The Institute of Gerontology, The University of Michigan-Wayne State University, 520 East Liberty, Ann Arbor, Michigan 48109.

July 22-24 — MSMS Council, Deer Lake, Boyne Falls, Michigan, contact: Warren Tryloff, MSMS Director.

Aug. 6-10 — Annual Convention and Scientific Assembly of the Michigan Academy of Family Physicians, Sugar Loaf Mountain, contact: Charles Schoff, MD, 5209 Sunset Drive, Midland, Michigan 48640.

Sept. 7 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director.

Nov. 2 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director.

Dec. 14 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director.

DR
MARK CAMPBELL

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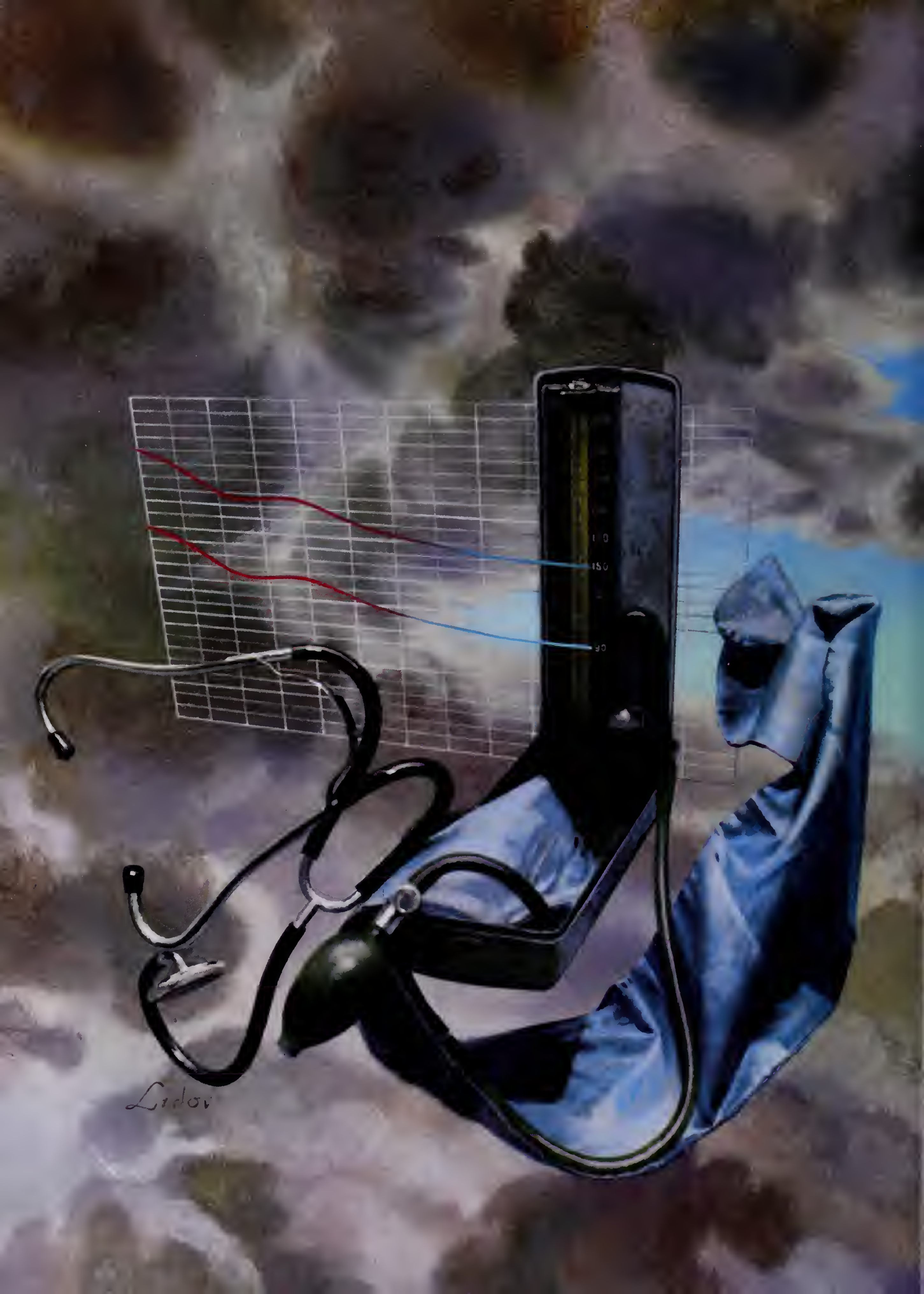
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References:

1 Dornfeld L, Kane R: Metolazone in essential hypertension The long-term clinical efficacy of a new diuretic *Curr Ther Res* **18**: 527-533, 1975
2. Data on file, Medical Department, Pennwalt Prescription Products

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* **Indications:** When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

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Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K+ intake. **The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy.** Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium® (triamterene, SK&F Co.), and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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Lord Porrit

British Health Service has lessons for us

(The following observations are excerpted from an illuminating talk on the British National Health Service entitled "Death of an Ideal." The talk was given at McLaren General Hospital, Flint, by Lord Porritt, who described "the rape of British medicine" by the National Health Service, and goes on in the following to suggest solutions to his country's health care delivery ills. His suggestions should serve as words to the wise in our country, which is facing national health insurance.)

By Lord Porritt
London, England

I tell you the somewhat sad story of the NHS in Britain — in the hope that it will point a way to better things, particularly in this great country of yours which surprisingly enough, has still to make up its mind about what kind of state medical service it wants. I would stress now that the whole essence of my thesis is that that choice should be made — taking into consideration the best and the worst features of the many and varied systems that now exist throughout the world and the particular domestic conditions which are peculiar to this country — by the profession and *not* by the Government.

Let us recapitulate briefly the major problems we will have to face — as learned from 30 years first-hand experience of the British system — to establish a service equally of benefit to the patient, the doctor and the nation.

A humanitarian profession has come into head-on collision with an impersonal governmental machine; financial concerns have taken precedence over clinical and ethical standards; expensive hospitalization (institutionalism) has become the order of the day, so isolating the patient from his home environment; treatment has become more technical and scientific rather than personal, to the great detriment of that basic principle of all good medicine — the doctor-patient relationship; clinical and ethical standards have become increasingly geared to a regimented methodology — as have the curricula of both under-graduates and post-graduates, so producing a new type of doctor; fear of a state monopoly has steadily grown, threatening loss of independence and freedom of choice both to doctor and patient and producing a markedly low morale in the profession; and all this has taken place in a rapidly changing socio-economic environment.

Realistic view needed

How do we cope with such a frightening collection of problems as this?

First, a genuinely and honestly realistic view of the situation is essential — unbiased by any political dogma, especially party political dogma. The basic purpose of the exercise is to provide a health service for the community to the best of the nation's financial ability. And let the words "health service" mean what they say! The British model to date has been essentially a "disease service" — and has sadly become a "diseased service!"

So far *no* country in the world has been either able or willing to provide from its gross national product sufficient funds to ensure the initiation and maintenance of a comprehensive state medical service. In Britain now the relevant figure is 5.5% of the GNP — which translated into money means almost 100 pounds per head of the total population — men, women and children.

And yet patently this is completely inadequate — as evidenced by underpaid staff, inability to replace out-of-date hospitals or even to maintain reasonably old ones, and failure to keep facilities up to modern levels — all of which inevitably lead to an overall fall in the standards of medical care.

Lord Porritt is surgeon to Queen Elizabeth II, former governor-general of New Zealand and former president of the Royal College of Surgeons. He recently chaired a four-year commission to study national health care in England, which recommended more fee-for-service and the end of the exclusive medical franchise of the National Health Service.

Regarding medical remuneration in the national service, some 10 years ago a doctor on average was receiving about five times the wages of a top manual laborer. Now it is reduced to three times — and British physicians' salaries are almost ludicrously below those of Europe, America, Canada and Australia.

Hence it would seem only logical to find other methods of ensuring over-all medical care for the community.

Of other methods of providing medical care, one need only mention private practice, insured practice, subsidized practice or some combination of these.

Many examples of such arrangements now can be found throughout the world — and the diversity of method well merits close study. Many schemes far less ambitious than the British one have resulted in far better end products. Certainly one of the best at the moment is the Australian scheme — based on compulsory national insurance (except for the destitute) backed by state subsidy as and where necessary. Two other countries that seem to have come to terms with a broad based and efficient system are France and Canada — where all patients enjoy the status of private patient.

In respect of economies, the first and obvious field lies with administration. The British service has given — and unfortunately still is giving — ample proof of this. Radical stream-lining is vitally necessary. Multiplication of levels of control is so easy to initiate, so difficult to curb and the result is always delay, reduplication of work and inefficiency. Such is bureaucracy! It is in this connection that a national service governed by an independent corporation has come under discussion — a concept again well worthy of consideration.

A more contentious, but very rewarding, possible field for economy lies in the present day over-emphasis on hospital treatment as such in contradiction to primary care and community health. There is no doubt that it would be very difficult to dislodge the prestigious acute general or special hospital from pride of place in the medical hierarchy. And yet it has been shown in the British scene that the hospital part of the medical service accounts for about 70% of total expenditure while providing benefits for something less than 10% of the population.

Relatively far greater dividends would be forthcoming and considerable savings made by expending less on hospitals and more on community medicine, the work of general practitioners, small local country and urban hospitals, health centers, both the teaching and practice of health, education and preventive medicine and the development of occupational and industrial health services.

Questions to ask

Do we make optimum use of our trained nursing and medical strength? Do we train enough para-medical personnel and deploy them to best advantage? Do we obtain maximum benefit from our available facilities — both equipment and buildings? Do we, without wasting valuable clinical time in managerial activities, keep a sufficiently vigilant eye on our self-perpetuating administration?

These are just a miscellany of questions which will demand answers if a state medical service is to be set up and be economically viable.

In the question of new monies I have already raised the possibility of management by an independent corporation; I would plead for some form of fee-for-service method of payment of doctors — both in practice and in hospital. One has seen the possibility in the former of the artificial creation of work (you in America have faced this problem with Medicaid) — but worldwide experience has shown this problem very soon becomes self-regulatory. And on the other hand it does possess the great advantages of maintaining the essentially basic personal doctor-patient relationship; it does reward actual work done and reflect the nature of that work and it does stimulate initiative and a sense of responsibility.

Further to produce "new monies" I would suggest "board and lodging" charges for all state patients in hospitals and similar modest fees for all "frill benefits." These, in the mass producing a considerable accretion of funds, would give the patient his sense of responsibility and would tend to maintain his independence and individuality.

And finally the question of morale; no state medical service will flourish or "produce the goods" unless its morale is high and is kept high. It is the insidious sapping of morale in the medical and nursing services of the British system that has finally brought it to its knees in the last year or so.

Medicine and politics

Politics and medicine are by their very nature immiscible. On the assumption therefore that nationalized medicine produces most good for most people (and this itself is of course arguable, though it seems today to be an accepted fact of international life!) — it is essential to produce a satisfactory medico-political emulsion. Such a mixture demands all the cooperation, mutual trust and understanding that both sides can give it.

It is all too easy for the emulsion to settle out into its two separate layers — and to prevent this the government concerned must go out of its way to inculcate into the profession a sense of being fairly treated; it must provide freedom of choice for the patient of his doctor and vice-versa and give the doctor the right to decide how, where and under what conditions he can work to the best of his ability; and it must ensure for the doctor his professional freedom to the extent that he himself as an individual is responsible for his own ethical and clinical standards.

A lot to ask, you may fairly say — in fact, perhaps an unattainable ideal. But looking round this grey world of ours, it is already obvious that it is those governments which are prepared to ride their medical profession on a light rein that have achieved the most economic and the most efficient state medical service.

NHI proponents better have good alternative to present system

Doctor Swan

(The following is reprinted with permission from a recent issue of Detroit Medical News.)

By Lionel F. Swan, MD Detroit

According to many politicians and members of the news media, the present system of free enterprise medicine has failed, and must be replaced by National Health Insurance. They are dissatisfied with the present system largely for the following reasons:

1. It is entirely too costly;

2. Its benefits do not reach all citizens, and

3. Many government programs like Medicaid are abused by "cheaters."

The critics gloss over the fact that the advances in medical knowledge (and other environmental factors) have raised the health indices to the highest level in the nation's history. For example: Life expectancy is now 74.2 years, infant mortality is 16.2 per thousand, and overall mortality is below 9 per thousand.

Logically, therefore, National Health Insurance would be expected to maintain or improve on this record, while correcting some of the inadequacies of the present system.

Consider costs. It has been estimated that all the money paid to doctors (including the "cheaters") amounts to between 12 and 15 percent of the health dollar. The rest goes for hospitals, pharmaceuticals, nursing homes, laboratories, etc. One item often overlooked is the magnificent stipend paid administrators and other bureaucrats who control the system. Many of these latter earn considerably more in salaries and fringe benefits than most doctors.

If costs are to be controlled, therefore, it would seem that the government will have to employ all doctors at rigidly controlled salaries, take over and operate all hospitals, nursing homes, laboratories, drug houses, etc., pay all personnel and malpractice premiums — in short take over the entire health industry.

Whether this will encourage more Americans to enter the arduous and time consuming field of medicine, in all its specialties, and continue the improvement in the diagnostic and technical tools, and pharmaceuticals which have contributed significantly to the advancement of medicine, is open to debate.

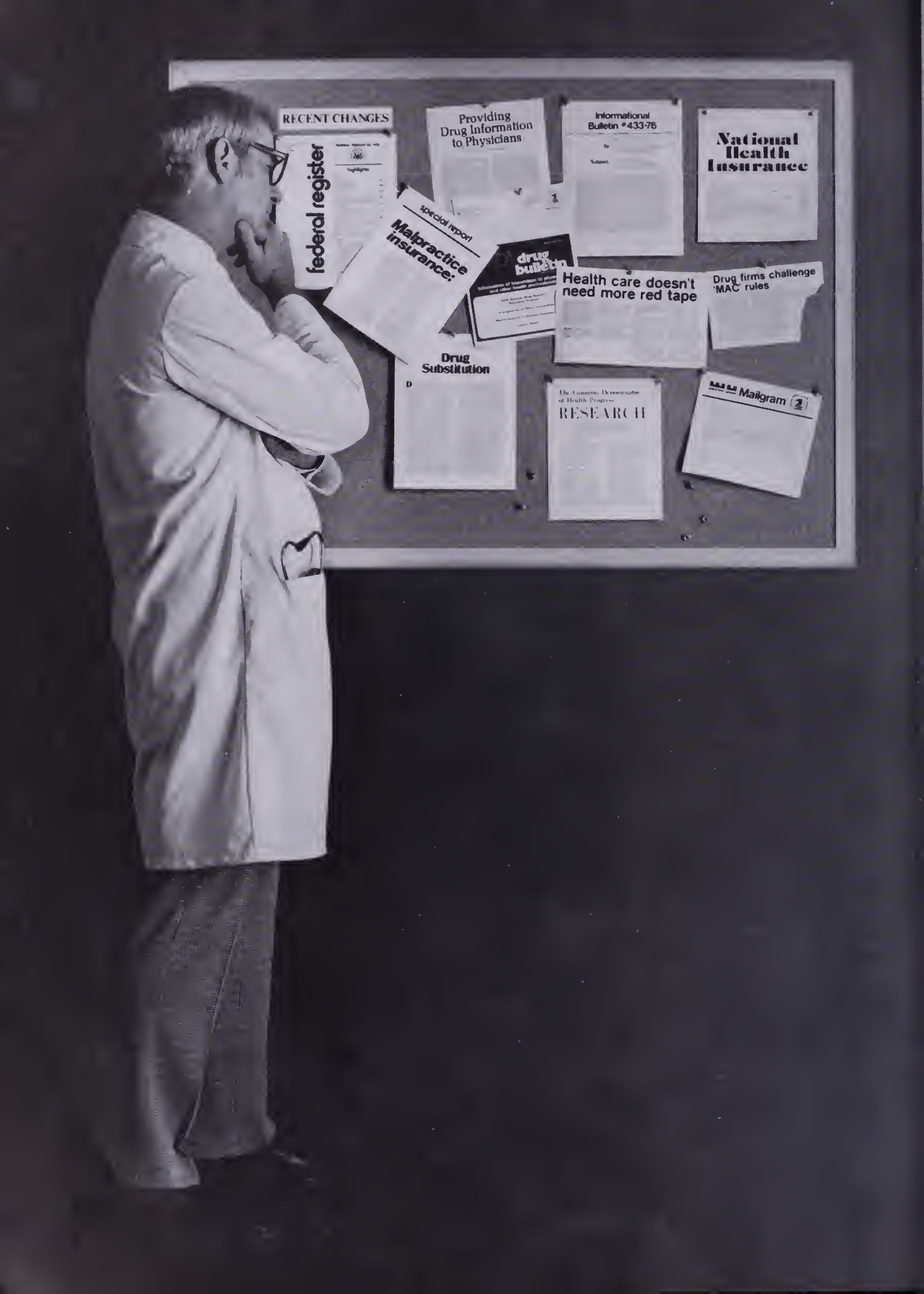
The critics are right when they state that *all* citizens do not benefit from the improvements in health care. The delivery among the poor, especially the "Inner City" poor and in rural areas is woefully inadequate. The health indices are correspondingly much lower. To correct this, more doctors should be encouraged to establish comprehensive health centers in these areas by such means as low-interest loans or tax "breaks."

The alternative would be for the government to conscript and assign doctors and other health personnel to these underserved areas.

The matter of "cheaters" has frequently been raised. Unquestionably there are "cheaters," but they represent a miniscule minority, and they are aided and abetted by a Medicaid system which pays so poorly and inconsistently, and has so complicated a reporting system, that a large number of private practitioners refuse to treat Medicaid recipients. The overwhelming majority of the few doctors who treat a significant number of Medicaid patients are dedicated professionals who work long hours and give their best to their patients, Senator Moss notwithstanding. "Cheaters" can be eliminated by simplifying Medicaid reporting procedures, paying more adequately and consistently, and prosecuting to the full extent of the law all those found guilty of abusing the system for personal gain. However, the search for "cheaters" should go beyond doctors and include among others, the administrative personnel of the various agencies dealing with health matters.

I have the highest respect for the integrity, intelligence and dedication of those who advocate National Health Insurance. I applaud their desire to make the advances in Medicine available to all our citizens. However, I feel that these advocates owe it to the American people to outline, in detail, how they propose to implement it before we abandon a system which, with all its faults, is working fairly well, and with some major adjustments, may work better.

Doctor Swan is a family physician.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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

P·M·A

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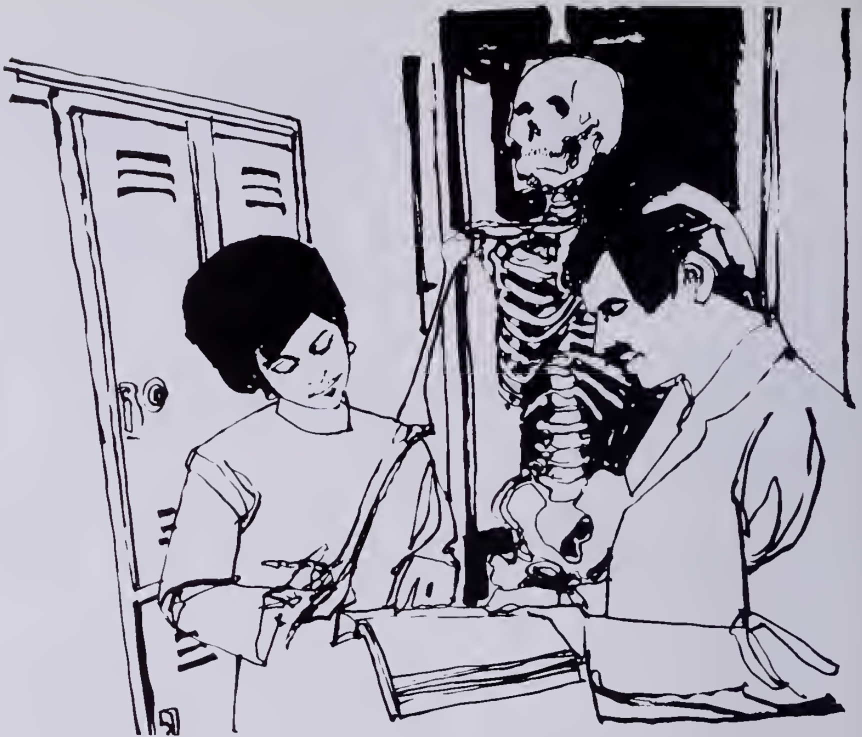
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Today, 25% of medical students are female

By Willah Weddon
Special to Michigan Medicine



Although parents of sons may not take much comfort from recent admission statistics of medical schools, those with daughters aspiring to be doctors should be encouraged.

During the past five years the number of women admitted to medical schools in the nation has more than doubled. This has led to an all-time high in the percentage of women in total enrollment.

Nearly one-quarter of the 15,364 students accepted in the 114 medical schools last fall were women, another record breaker. According to an Association of American Medical Colleges report, today's 23.7 percent compares to 11.3 percent in 1970-71, a dramatic increase over the 4.5 percent of women accepted from all applicants in 1929-30.

Michigan statistics

Michigan State University's College of Human Medicine ranks third in the nation in percent of women enrolled. This is expected to increase as the number of women admitted has climbed annually, to approximately 40 percent last fall.

At the University of Michigan Medical School, women make up 25.8 percent of the total enrollment today, compared to 11 percent in 1971-72.

Wayne State University's School of Medicine is composed of 18 percent women. This represents a steady increase since the 11% who were females in 1972-73.

Despite the proportionate gains, however, actual figures reveal room for continued growth in female admissions before they approach equal representation of the total population. 157 of 420 medical students at MSU, 247 of 957 at U of M and 186 of 1,022 at WSU are women.

The trend to admit more women to medical schools has undoubtedly been influenced by federal regulations against discrimination on the basis of sex in federally-funded education programs. Enforced with the clout of dispensing or withholding federal dollars, the emphasis on affirmative action programs cannot be discounted.

Judith Krupka, associate dean for student affairs and admission, College of Human Medicine at MSU, attributes the high proportion of women there, however, to the fact that more of them were accepted when the school opened in 1972, than in the other medical schools.

"This attracted more female applicants," she said. "We have a larger proportion of women applicants and therefore the percentage of admission is also higher.

"When the Association of American Medical Colleges urged schools not to discriminate against women, their enrollment jumped dramatically," she added.

Mrs. Frankie French, U of M registrar for the Medical School, pointed out that their number of applicants corresponds percentage-wise to the number of women they admit.

Marilyn Heins, MD, associate dean for student affairs, WSU School of

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Medicine, however, is convinced the trend preceded the affirmative action program.

Feminist influence

"I think the upward trend in admissions of women has more to do with the feminist movement," she said. "Women were made aware that there was another option for them beside the traditional role of housewife and mother."

Noting that a larger percentage of women applicants are accepted than men, Doctor Heins said, "I think it's because they're better students."

In 1971, 45.1 percent of all women applying for admission to medical schools in the country were accepted while only 41.9 percent of the total number of men applying were accepted. Last fall the women applicants had a 38 percent rate and the men only 35 percent.

One of the hurdles women have faced is the belief that they will take valuable space in classes from men during their training and not use it when they bear children. Doctor Heins contends that only seven percent of the women with medical degrees do not practice due to being a woman.

Mary Nichols Bentley, MD, of Jackson, is among the women who have helped dispel the myth. Admitted in 1947 to the University of Michigan Medical School, she was one of eight women in a class of 145. Six of the women graduated in a class of 114 and, according to the latest information she has, they are all still in some form of medical practice.

Doctor Mary married Jack Bentley, MD. She took periods of about three weeks each from her family practice when their four daughters were born, and the couple continues to share an office at 2532 Spring Arbor Road.

"I wouldn't think of doing anything else," she replied when asked if she would do it all over again.

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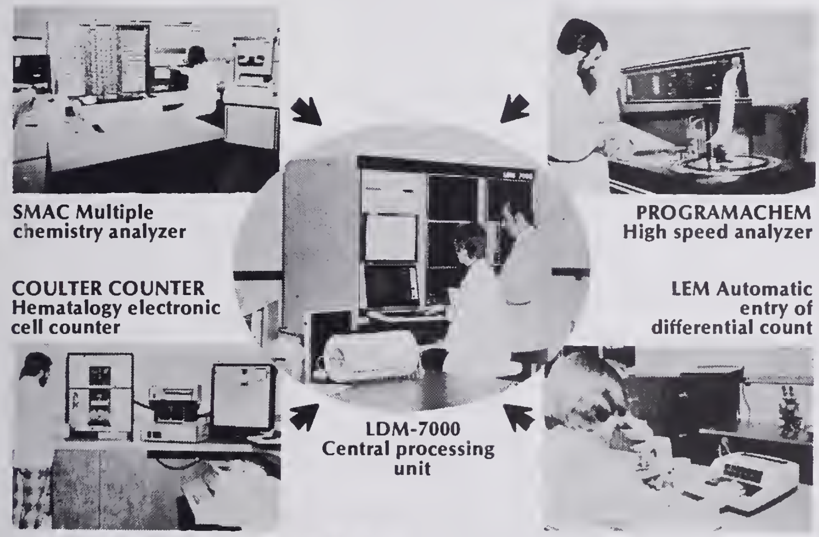
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FEMALE MDs / *Continued*

"I think it's marvelous that there are more women coming into the field," she said, regarding the trend today.

Women MDs accepted

Along with the change in attitude by society toward women working outside the home has come an acceptance by their peers in the medical world. "Most male doctors accept female doctors on an equal basis today," said Ralph Lewis, executive director of the Council of Medical School Deans in Ann Arbor. "But I suppose you could find a few who still object to women becoming doctors."

Will the trend continue?

It is anticipated that it will. Doctor Heins predicts that within seven years 25 percent of all practicing physicians will be women, compared to approximately 10 percent today.

The rapid rate of increase, however, could be slowed somewhat if the US Supreme Court decision is rendered against the quota system of admissions to medical schools. The University of California Medical School has voted to appeal a case charging reverse discrimination against it (filed by Marco DeFunis) which was upheld by the California Supreme Court.

Although spokesmen for Michigan's three medical schools state they do not have a quota system, attention is focusing on the Court's action. The ramifications of such a ruling would undoubtedly extend to other affirmative action programs.

Detroit MDs report in *JAMA:* 84% of female doctors working

Women doctors are doing their full share of caring for patients, along with being wives and mothers, a survey in the Detroit area indicates.

Of women physicians surveyed by a research group from Wayne State University, 84 percent were engaged in medical work, most of them full time. Only seven percent were not working for reasons related to being a woman, notably staying home to care for children and household. And some of those not working were retired or disabled, as the age range of the survey was from 30 to 86 years.

More than half of the women doctors are in private practice and in primary care specialties. More than half are board certified.

Doctors often marry doctors, the survey found. Some 67 percent of the feminine physicians were married, 43 percent of them to doctors.

There are currently more than 30,000 women physicians in America, more than eight percent of all doctors. But the number of women in medical schools has been rising rapidly, and in another few years one fourth of all physicians will be women, the report says.

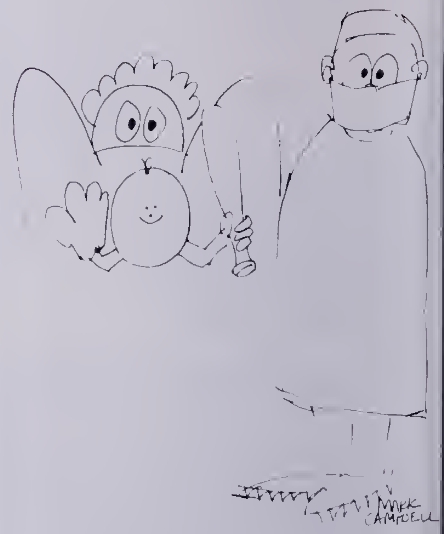
Marilyn Heins, MD, associate dean for student affairs, Wayne State University, and colleagues in the survey point out that women physicians still are faced with the assumption that they must be wife, mother, cook and housekeeper.

"The assumption that women automatically have total responsibility for household maintenance and child rearing needs to be challenged. Shared responsibility of these important tasks seems to be a crucial issue," Dr. Heins declares.

"Raising our children of both sexes to accept shared responsibilities for child care and household maintenance may be one of the most important cultural changes of child rearing in this century.

"Given the high productivity of women physicians found in our study, it is no longer tenable to state that women physicians do not work at an acceptable level," she concludes.

The report is published in the Oct. 25 *Journal of the American Medical Association.*



"Looks like a boy from here."

Artist Mark Campbell, MD is a Grand Rapids family physician.

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Category I Courses

Michigan Medicine *each month will carry a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of the new Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing will indicate a contact person, so the physician can obtain details. The list will be expanded as courses are developed by accredited sponsors. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.*

Date: Feb. 16, Lecture Series in Ophthalmology, "The COß Laser in Ocular Surgery." Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Ophthalmologists. **Cost:** No charge. **Contact:** Department of CME, Sinai Hospital of Detroit****. **Approved for:** 2 hours of Category I Credit.

Date: Feb. 21-25, Emergency Medicine. Location: Towsley Center, Ann Arbor. **Sponsor:** U of M Office of Intramural Education*. **Co-sponsor:** American College of Emergency Physicians, Michigan Chapter. **For:** Emergency physicians. **Cost:** $225 for physicians, $135 for physicians-in-training. **Contact:** U of M Office of Intramural Education*. **Approved for:** Approx. 36¼ hours of Category I Credit.

Date: February 21 - April 25, Pediatric Seminars - II. Location: Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital. **For:** Pediatricians. **Cost:** $200. **Contact:** Linda Radu, Dept. of Medical Education, St. John Hospital, 22101 Moross Road, Detroit, 48236. **Approved for:** 20 hours of Category I Credit.

Date: Feb. 23, Tumors of the Bone — Primary and Metastatic. Location: Grace Central Hospital. **Sponsor:** WSU School of Medicine Dept. of Oncology. **For:** All interested physicians. **Cost:** $20. **Contact:** Dorothy Bewley, Dept. of Oncology, Wayne State University, 4160 John R., Detroit, 48201. **Approved for:** 2½ hours of Category I Credit.

Date: March, A Course on Clinical Depression, Part III — "Clinical Depression: Current Concepts of Diagnosis." Location: Televised: WEYI-TV, CBET, WUHQ-TV. **Sponsor:** University of Pennsylvania. **Co-sponsor:** Pfizer Laboratories Division. **For:** Primary care physicians. **Cost:** $5. **Contact:** Ms. Anne Hearn (215-662-2849), or your local Pfizer Representative. **Approved for:** Up to 9 hours of Category I Credit.

Date: March 1, Pathology Conference. Location: Towsley Center, U of M Medical Center. **Sponsor:** U of M Medical Office of Intramural Education. **For:** Pathologists. **Cost:** $60. **Contact:** U of M Office of Intramural Education*. **Approved for:** Approximately 6 to 7 hours of Category I Credit.

Date: March 2, "Cell Kinetics as Related to Cancer Therapy," with Dr. Emil J. Freireich — visiting lecturer. Location: Zuckerman Auditorium, Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital Department of Medicine. **For:** Internists, Hematologists, Oncologists. **Cost:** None. **Contact:** Arnold R. Axelrod, MD, Sinai Hospital, (313) 272-6000. **Approved for:** 2 hours of Category I Credit.

Date: March 2-3, Advances in Pediatrics. Location: Towsley Center, U of M Medical Center. **Sponsor:** U of M Office of Intramural Education. **Co-sponsor:** Mich. Chapter, American Academy of Pediatrics. **For:** Pediatricians. **Cost:** $120. **Contact:** U of M Office of Intramural Education*. **Approved for:** 13¾ hours of Category I Credit.

Date: March 14-15, Difficult Problems Encountered in the Practice of General Surgery. Location: Towsley Center, U-M Medical Center. **Sponsor:** U of M Office of Intramural Education. **For:** Surgeons. **Cost:** Approximately $120. **Contact:** U of M Office of Intramural Education*. **Approved for:** Approximately 13 to 14 hours of Category I Credit.

Date: March 15, Cancer of the Colon and Rectum. Location: Wayne County Medical Society headquarters, 1010 Antietam, Detroit, 48207. **Sponsor:** WSU Department of Oncology. **For:** All interested physicians. **Cost:** $20. **Contact:** WSU Division of CME***. **Approved for:** 2½ hours of Category I Credit.

Date: March 16, Lecture Series in Ophthalmology, "The Treatment of Lid Elevation." Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Ophthalmologists. **Cost:** No charge. **Contact:** Department of CME, Sinai Hospital of Detroit****. **Approved for:** 2 hours of Category I Credit.

Date: March 20 - June 8, Clinical Nuclear Medicine II. Location: Scott Hall, Wayne State University. **Sponsor:** WSU Department of Radiology. **For:** Radiologists. **Cost:** $66. **Contact:** WSU Division of CME**. **Approved for:** 20 hours of Category I Credit, 2 hours per session.

Date: March 23, Infant Nutrition: A Foundation for Lasting Health. Location: Veteran's Memorial Building, 151 West Jefferson Avenue, Detroit. **Sponsor:** The University of Iowa College of Medicine, and the National Heart, Lung and Blood Institute. **Co-sponsor:** The National Kidney Foundation, The Committee on Atherosclerosis and Hypertension in Childhood, and the Council on Cardiovascular Disease in the Young of the American Heart Association. **For:** All interested physicians, via a closed circuit symposium. **Cost:** None. **Contact:** Pat Coleine, Health Learning Systems Inc., % Health Projects International, Inc., 200 Madison Avenue, New York, 10016. **Approved for:** 34 hours of Category I Credit, (The TV symposium: 3 hours, Pre & Post Tests: 14 hours, Supplementary study: 8 hours, Visiting Faculty: 9 hrs)

Date: March 23, Heart Day. Location: Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital. **For:** Cardiologists. **Cost:** $50. **Contact:** Linda Radu, Dept. of Medical Education, St. John Hospital, 22101 Moross Road. **Approved for:** 7 hours of Category I Credit.

Date: March 23, Carcinoma of the Uterus. Location: Grace Central Hospital. **Sponsor:** WSU School of Medicine. **For:** All interested physicians. **Cost:** $20. **Contact:** WSU Department of CME**. **Approved for:** 2½ hours of Category I Credit.

Date: March 23-24 — Winter-Spring Perinatal Conference and Northeastern Wisconsin Perinatal Program. Location: Terrace Motor Inn, Escanaba. **Sponsor:** Northeastern Wisconsin Perinatal Intensive Care Unit, St. Francis Hospital, Escanaba, and MSU UP Medical Education Program. **For:** All interested physicians. **Cost:** $20. **Contact:** William LeMire, III, MD, Doctors Park, Escanaba 49829. **Approved for:** To be determined.

Date: March 23 - June 7, Physics of Nuclear Medicine and Diagnostic Radiology. Location: Scott Hall, Wayne State University. **Sponsor:** WSU Department of Radiology. **For:** Radiologists. **Cost:** $66. **Contact:** WSU Division of CME**. **Approved for:** 20 hours of Category I Credit, 2 hours per session.

Date: March 24-25, Hematology Review: Morphology and Laboratory

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*Office of Intramural Education, University of Michigan Medical Center, Dep't. of PGM/HPE, Ann Arbor, 48109

**WSU Division of CME, Room 1209, Scott Hall, 540 E. Canfield, Detroit, 48201 (313) 577-1453

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902

****Department of CME, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 272-6000

Techniques. **Location:** Towsley Center, U of M Medical Center. **Sponsor:** Simpson Memorial Institute, U of M Departments of Internal Medicine and PGM/HPE. **For:** Clinicians and laboratory personnel. **Cost:** $80. **Contact:** U of M Office of Intramural Education*. **Approved for:** 12½ hours of Category I Credit.

Date: March 26-27, AMA Regional Program. Location: Michigan Inn, Southfield. **Sponsor:** AMA and MSMS. **For:** All interested physicians. **Cost:** $140. **Contact:** AMA Council on Scientific Assembly, 535 N. Dearborn, Chicago 60610. **Approved for:** 12 hours of Category I Credit.

Date: March 30 — Symposium on Congenital Heart Diseases in Infants, Children and Adults. Location: Haufman House Mid-Way Motor Lodge, Grand Rapids. **Sponsor:** Michigan Heart Association. **For:** All interested physicians. **Cost:** $30. **Contact:** Michigan Heart Association, 16310 W. Twelve Mile, PO Box LV-160, Southfield 48076. **Approved for:** 5 hours of Category I Credit.

Date: March 30-31 — Annual Michigan Conference on Maternal and Perinatal Health. Location: Kalamazoo Center Inn, Kalamazoo. **Sponsor:** MSMS. **For:** All interested physicians. **Contact:** Herbert Auer, MSMS headquarters. **Approved for:** Tentative 7 hours of Category I Credit.

Date: April 4 - June 18, Medical Cytogenetics. Location: Scott Hall, WSU School of Medicine. **Sponsor:** WSU Department of Pathology. **For:** Pathologists. **Cost:** $100. **Contact:** WSU Division of CME**. **Approved for:** 20 hours of Category I Credit, 2 hours per session.

Date: April 5-6, Obstetrics and Gynecology Conference. Location: Towsley Center, U of M Medical Center, Ann Arbor. **Sponsor:** U of M Office of Intramural Education. **For:** Obstetricians/Gynecologists. **Cost:** $100. **Contact:** U of M Office of Intramural Education*. **Approved for:** 11½ hours of Category I Credit.

Date: April 6, Dermatology for the Generalist and Internist. Location: Zuckerman Auditorium, Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Dermatologists, internists and generalists. **Cost:** To be determined. **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 3 hours of Category I Credit.

Date: April 14, 1977 Michigan Conference on Medical Aspects of Organized Athletics. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** MSMS CME Programming Committee. **For:** All interested physicians. **Contact:** Herbert Auer, MSMS headquarters. **Approved for:** 5 hours of Category I Credit.

Date: April 18-22, Family Practice Review. Location: Towsley Center, U-M Medical Center, Ann Arbor. **Sponsor:** U of M Office of Intramural Education. **Co-Sponsor:** Mich. Academy of Family Physicians. **For:** Family Physicians. **Cost:** $250. **Contact:** U of M Office of Intramural Education*. **Approved for:** 37½ hours of Category I Credit.

Date: April 19-21, Physiology of the Ovary. Location: Scott Hall, WSU School of Medicine. **Sponsor:** WSU Department of Gynecology and Obstetrics. **For:** Obstetricians/Gynecologists, Family physicians. **Cost:** $100. **Contact:** WSU Division of CME**. **Approved for:** 20 hours of Category I Credit.

Date: April 20, Lecture Series in Ophthalmology, "The Pediatric Patient with Nystagmus." Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Ophthalmologists. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 12 hours of Category I Credit.

Date: April 21-23, Critical Care Symposium, "Monitoring of the Critically Ill." Location: Wayne County Medical Society, 1010 Antietem Road, Detroit. **Sponsor:** WSU School of Medicine. **For:** All interested physicians. **Cost:** $95 physicians in practice; $45 physicians in training. **Contact:** WSU Division of CME**. **Approved for:** 12 hours of Category I Credit.

Date: April 26-28, Electrocardiograph Diagnosis. Location: Towsley Center, U of M Medical Center, Ann Arbor. **Sponsor:** U of M Medical School DPM/HPE, Office of Intramural Education. **For:** Family physicians, internists. **Cost:** $180. **Contact:** U of M Office of Intramural Education*. **Approved for:** 20 hours of Category I Credit.

The following have been accredited by MSMS Commission on Continuing Medical Education:

Organizations:

Ann Arbor Psychiatric Association
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Society of Anesthesiologists
University of Michigan School of Public Health

Hospitals:

Alma-Gratiot Community Hospitals, Alma
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med.Center, PC/Little Traverse Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Detroit-Macomb Hospital Association
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Henry Ford Hospital, Detroit
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital), Muskegon
Marquette General Hospital
McLaren General Hospital, Flint
Mercy Hospital, Port Huron
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Oakland Medical Center, Pontiac
Oakwood Hospital, Dearborn
Pontiac General Hospital, Pontiac
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Edward Sparrow Hospital, Lansing
Traverse City State Hospital, Traverse City
V. A. Hospital, Battle Creek
Wayne County Psychiatric Hospital, Eloise
West Shore Hospital, Manistee
Ypsilanti State Hospital, Ypsilanti

Date: April 29-30, 10th Annual Cancer Symposium. **Location:** Scott Hall, WSU School of Medicine. **Sponsor:** WSU Department of Oncology. **For:** All interested physicians. **Cost:** $75. **Contact:** WSU Division of CME**. **Approved for:** 14 hours of Category I Credit.

Date: May 4, Recent Advances in Pediatric Surgery. **Location:** Children's Hospital of Detroit. **Sponsor:** WSU Department of Pediatrics. **For:** Pediatricians, family physicians, surgeons. **Cost:** $35. **Contact:** WSU Division of CME**. **Approved for:** 6¼ hours of Category I Credit.

Date: May 5-6, "Annual Clinic Days," Recent Advances in Pediatrics. **Location:** Children's Hospital of Detroit. **Sponsor:** WSU Department of Pediatrics. **For:** Pediatricians. **Cost:** $75. **Contact:** WSU Division of CME**. **Approved for:** 12 hours of Category I Credit.

Date: May 5-6, Ophthalmology Conference: Cornea and External Disease. **Location:** Towsley Center, University of Michigan Medical Center. **Sponsor:** U of M Medical School PGM/HPE. **For:** Ophthalmologists. **Cost:** $140. **Contact:** U of M Office of Intramural Education*. **Approved for:** 14 hours of Category I Credit.

Date: May 11, Common Clinical Problems in Pulmonary Disease. **Location:** Kalamazoo Hilton Inn. **Sponsor:** Southwestern Michigan Area Health Education Center. **For:** Any interested physicians. **Cost:** $10. **Contact:** Charles Zeller, SMAHEC, (616) 383-6398. **Approved for:** 7 hours of Category I credit.

Date: May 12, Common Dermatologic Problems. **Location:** Towsley Center, U of M Medical Center. **Sponsor:** U of M Office of Intramural Education. **Co-sponsor:** Michigan Academy of Family Physicians. **For:** Family physicians. **Cost:** $60. **Contact:** U of M Office of Intramural Education*. **Approved for:** 6 hours of Category I Credit.

Date: May 12-13 — Annual Heart Days. **Location:** Hyatt Regency Dearborn. **Sponsored by:** Michigan Heart Association. **For:** All interested physicians. **Cost:** $40. **Contact:** Michigan Heart Association, 16310 W. Twelve Mile, PO Box LV-160, Southfield 48076. **Approved for:** 12 hours of Category I credit.

Date: May 16-20, Advances in Internal Medicine. **Location:** Towsley Center, U of M Medical Center. **Sponsor:** U of M Office of Intramural Education. **For:** Internists. **Cost:** $225. **Contact:** U of M Office of Intramural Education*. **Approved for:** 35 hours of Category I Credit.

Date: May 17, Cancer of the Cervix. **Location:** Wayne County Medical Society, 1010 Antietam, Detroit. **Sponsor:** WSU Department of Oncology. **Co-sponsor:** Detroit Cancer Club. **For:** All interested physicians. **Cost:** $20. **Contact:** Dorothy Bewley, Dept. of Oncology, Wayne State University, 4160 John R., Detroit 48201. **Approved for:** 2½ hours of Category I Credit.

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Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Marc S. Arnkoff, MD
22255 Greenfield Rd. #430
Southfield 48075

Dennis F. Dettloff, MD
2254 Woodview
Alpena 49707

Ananias C. Diokno, MD
3459 Yellowstone Dr.
Ann Arbor 48105

Anthony W. Fairclough, MD
909 Woodward Ave. #115
Pontiac 48053

Michael D. Gunzenhaeuser, MD
2440 Abbington, S.E.
Grand Rapids 49506

Hugo R. Hernandez, MD
31248 Verona
Farmington Hills 48018

Conrad S. Heyner, MD
15901 W. 9 Mile Rd. #400
Southfield 48075

Kenneth Kar-Hon Ho, MD
4778 Tyndale Ct.
West Bloomfield 48033

Fuad F. Khaznehkatbi, MD
628 N. Woodward Ave.
Birmingham 48011

Douglas W. Klakulak, MD
3535 W. 13 Mile Rd. #501
Royal Oak 48072

Young Dai Lee, MD
3744 Karen Pkwy. #202
Pontiac 48054

George A. McCarty, MD
3535 W. 13 Mile Rd. #504
Royal Oak 48072

Stephen W. Sturman, MD
23133 Orchard Lake Rd. #201
Farmington 48024

Denis E. Walsh, MD
555 E. William 20-D
Ann Arbor 48014

CATEGORY I / *Continued*

Date: May 18, Pediatric Dermatology Seminar. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** Pediatricians, family practitioners, dermatologists. **Cost:** $50. **Contact:** Office of CME, St. John Hospital, Detroit, (313) 881-8200, ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: May 25, Multiple Myeloma. Location: Grace Central Hospital. **Sponsor:** WSU School of Medicine. **For:** All interested physicians. **Cost:** $20. **Contact:** Dorothy Bewley, Department of Oncology, Wayne State University, 4160 John R., Detroit 48201. **Approved for:** 2½ hours of Category I Credit.

Date: May 26, Pathology Conference. Location: Towsley Center, U of M Medical Center. **Sponsor:** U of M Office of Intramural Education. **For:** Pathologists. **Cost:** To be determined. **Contact:** U of M Office of Intramural Education**. **Approved for:** 6 hours of Category I Credit.

Date: Saturdays, Morbidity and Mortality Conference. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital Department of Surgery. **For:** Surgeons. **Cost:** None. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 2 hours of Category I Credit per session.

Date: Monthly, Cleft Palate Clinic. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Oral Surgeons, plastic surgeons, pediatricians. **Cost:** None. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 3 hours of Category I Credit.

Date: Monthly, Tissue Audit (Cancer). Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Surgeons, ob-gyns, pathology, radiology. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 2 hours per session Category I Credit.

Date: Second Thursday of each month, Inter-Hospital Pathology Slide Conference. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** Pathologists. **Cost:** No charge. **Contact:** Department of CME, St. John Hospital, 22101 Moross Road, Detroit, 48236, (313) 881-8200. **Approved for:** 3 hrs. each date Category I Credit.

Date: Every Tuesday morning, Gynecology/Obstetrics Combined Grand Rounds. Location: Jackson Auditorium, Hutzel Hospital. **Sponsor:** Wayne State University Department of Gynecology-Obstetrics. **For:** All interested physicians. **Cost:** No charge. **Contact:** Wayne State University, Division of CME**. **Approved for:** 4 hours each of Category I Credit.

Date: Every Saturday, Weekly Conference. Location: Gamble Building, Burns Clinic/Little Traverse Hospital, Petoskey. **Sponsor:** Burns Clinic/Little Traverse Hospital. **For:** All interested physicians. **Cost:** None. **Contact:** Ernest W. Carpenter, MD, 560 West Mitchell, Petoskey, 49770.

Date: Begins September, 1976, Continuing Training in Family Therapy. Location: Suite 1212, North Park Plaza, 17117 W. Nine Mile Road, Southfield. **Sponsor:** Family Institute of Southeastern Michigan. **Co-sponsor:** Ackerman Institute. **For:** Psychotherapists. **Cost:** Varies according to time put in. **Contact:** Carolyn R. Tourkow, MSW, director, Family Institute of Southeastern Michigan. **Approved for:** Hours vary with time spent.

Date: Each Wednesday, Detroit Medical Center Hand Conference. Location: Classroom 3, Second Floor, Webber Wing, Harper Hospital, Detroit. **Sponsor:** Wayne State University. **For:** Surgeons. **Cost:** No charge. **Contact:** Joseph L. Posch, MD, Fourteenth Floor, Kales Building, 76 W. Adams, Detroit 48226. **Approved for:** Hour-for-hour Category I credit.

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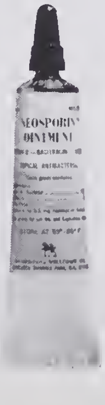
Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS**: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS**: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept PML



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How federal funds affect development of a regional emergency medical system

By Robert S. Brown, MD
Patricia J. Murphy, RN
Saginaw

Public and professional awareness of the need for an integrated emergency medical services (EMS) system has increased considerably over the past few years. This is partly due to successful regional and statewide trauma programs in Illinois and Maryland, which have received wide publicity, as well as other documentary and fictional media treatment of the subject. Public Law 93-154, which Congress passed in 1973, has placed the Federal Government on record as being committed to the upgrading of EMS in the United States. The purpose of this report is to examine the effect of Federal funding on a regional program after one year of operation.

Background

The geographic area for EMS system development corresponds to the boundaries of the local health planning agency. The area of fourteen counties in East Central Michigan with 11,463 square miles and a population of 737,000. The area is predominantly rural with the exception of two urban population centers in Bay City and Saginaw. Approximately 120,000 people are in the Bay City service area, and 220,000 in the Saginaw service area. An EMS committee was functioning as a component of the local health planning agency prior to the receipt of the Federal grant. This committee had concerned itself with a survey of emergency room capability in the area, review and comment upon applications for ambulances and radios, which would be funded by Federal matching grant programs, and the development of guidelines for EMS in the area.

In December of 1974, an ad hoc committee was established to examine feasibility of developing a regional trauma center. This ad hoc committee established a physicians' advisory committee so that the necessary professional expertise could be brought to bear on this question. The initial limited mandate of this physicians' committee was quickly expanded because a satisfactory answer to the trauma center question could not be given until there was an inventory and categorization of emergency room and professional resources within the area.

Request for Federal Funding

Before this examination of emergency resources could be completed, the Michigan Department of Public Health requested the local planning agency to submit an application for funds under the Federal EMS legislation. The initial grant proposal was developed as a staff effort with insufficient advice and direction from the local EMS committees. This resulted in the health planning agency and the voluntary consumer and physician committees being placed in an adversary relationship. This conflict was resolved after the physicians' advisory committee and the consumer-dominated EMS committee had an opportunity to review and revise the initial grant proposal.

Structure

The EMS committee consists of representatives from the entire 14-county geographic service area. A majority of its members are consumers. A permanent medical advisory committee consisting of a physician and nurse from each hospital in the 14 counties has been established to examine those questions which impact most directly on patient care and medical practices. In addition, the medical advisory committee has established seven technical advisory committees to cover the critical care areas as defined by the grant.

Doctor Brown is project medical director, and Ms. Murphy is executive administrator of the East Michigan Emergency Medical Services of Saginaw.

A bibliography is available from the authors on request. *This study was carried out under HEW Medical Services Grant #05H000487-02.*

First Year Activities

Organizational

After inventorying and categorizing emergency room resources within the area, the physician's advisory committee and the local EMS committee felt that efforts should be directed toward concentrating on the systems aspect, emphasizing education, interhospital cooperation, and communications, rather than the establishment of a regional emergency center.

With the preceding information at hand, the area was divided into four subregions with one of the general hospitals within each subregion designated as a medical control point. The purpose of the medical control point is to serve as a source of information to the hospitals and ambulance services within the area with respect to regional capability in the critical care areas. At times, this would involve transfer to the hospital designated as the medical control point; at other times, routing the patients from outlying hospitals to other points within the system where capability exists for the care of a particular problem. A coordinator is based at each control point. This person is an EMT with ambulance experience who supervises the communications network, coordinates transfers, and is responsible for the prehospital phase of the system in his region. The control point emergency room has 24-hour-a-day physician coverage and the capability of communicating with other hospitals and ambulances via frequencies 155.280 and 155.340.

Educational

One of the more productive areas in the past year was the establishment of educational programs for all levels of personnel within the system. Through newly developed or existing courses, over 200 EMT's were trained and every ambulance run within the 14 counties has at least one EMT-trained person in attendance. By 1977, the goal of two EMT's per vehicle should have been realized. Regional workshops dealing with critical care nursing, neurosurgical injuries, fetal monitoring, care of the trauma patient, and communications have reached approximately 800 professional personnel. A four-week trauma nurse program modeled after the Illinois trauma nurse specialist program was developed and the first class graduated in June of 1976. Over 450 volunteer man hours have been contributed to educational activities in the past year.

Pilot Programs

The EMS program was instrumental in the development of a complete hospital-ambulance communications system for one of the subregions in the eastern portion of the service area. In addition, a hospital agreement has been obtained and funds found for the establishment of a remote coronary care monitoring system, which will be the first in the State of Michigan. The EMS staff has also provided technical assistance to local government units who are establishing subsidized countywide ambulance services and assisted them in preparation of grant applications for federal funds for communication equipment.

Problem Areas In The First Year

Funding

A recent HEW decision that Health Systems Agencies (HSA's) could not receive EMS funds placed the entire program in jeopardy. A new non-profit organization had to be found to apply for the second year grant, office and staff had to be relocated; and committee structures had to be realigned to conform to federal guidelines. Approximately six to eight weeks' working time was lost during this reorganization.

Quarterly reporting requirements and preparation of proposals for subsequent funding occupy approximately 20% of the staff's time. At times, it seems as if the major effort of the program is directed toward self perpetuation, rather than implementation.

Federal funding and reporting requirements are not designed to promote staff efficiency and productivity. The funding cycle begins on July 1st of each calendar year and planning for funding the subsequent year's activities must begin in October and be completed by April. In addition, quarterly reporting and data collection requirements place considerable demands upon full time staff for activities which at times are only indirectly relevant to the objectives of the program. Greater efficiency and productivity would be achieved by funding programs on a two-year cycle with half-year reporting requirements to insure continuity and decrease non-productive staff activity.

Facilities and Manpower

The absence of a comprehensive hospital with a university-type residency program precludes any meaningful attempt at concentration of trauma patients. Trauma care is currently given at area hospitals with a basic or general capability, and alteration of existing referral patterns by channeling trauma patients to any single institution in the urban areas would strain both physical and professional resources at any of these institutions. Special care units such as the burn unit and a neonatal intensive care unit serve the entire 14 counties. Two hospitals within the region have full neurosurgical capability and have been designated as regional referral centers for these problems.

Equipment

Complete development of an integrated communications network and upgrading of vehicles and equipment to federal standards has been and will continue to be hampered by the fact that funds for these activities are channeled through separate federal programs. Matching money is available for radios and ambulances through the Office of Highway Safety Planning, and Department of Transportation but no matching funds for

EMERGENCY SYSTEM / *Continued*

ambulances were available during the final quarter of the first year of the EMS program.

Malpractice

Transfer and treatment protocols have been devised by the technical advisory committee, and identified as guidelines. The justifiable fear of the professional community is that written guidelines will be correctly interpreted as standards for care and deviations from these, for whatever reasons, carry with them the risk of exposure to malpractice action.

There has been considerable local physician involvement both in the conceptualization and implementation of an area EMS system. If development of a system results in greater malpractice action against physicians in the area, voluntary cooperation will come to a halt.

System Evaluation

The ultimate yardstick for performance of the system is some objective criteria upon which to base system performance. Unfortunately, an adequate data base does not exist within any of the categories, i.e., trauma, burn, cardiac, CNS injury, to form a basis of comparison and effectively evaluate the performance of the system in reducing mortality as has been done in Wisconsin. The Illinois program has developed a sophisticated data collection system, but the observed reduction in statewide highway mortality has been attributed to other factors such as lowering the speed limit to 55 miles an hour. System evaluation at the present time is anecdotal and will continue to remain so for the foreseeable future.

Summary

Federal funding has had a noticeable impact on development of an EMS system within East Central Michigan. Voluntary consumer and physician participation in the program predated the receipt of federal money and the activities of these groups were accelerated after receipt of federal funds. There now exists an awareness among the professional and lay community concerning the components of an EMS system, the position of this region with respect to other systems across the country, and an understanding of the system's deficiencies in this region.

Demonstrable progress has been made in identifying and coordinating the components of an EMS system within the region. Federal funds have made possible the initiation of educational and pilot programs which are new to the region.

Federal funding requirements and lack of coordination among federal programs will not be resolved in the foreseeable future. Passage of EMS legislation would acclerate system implementation but continued voluntary physician cooperation cannot be assumed if EMS related malpractice claims increase.

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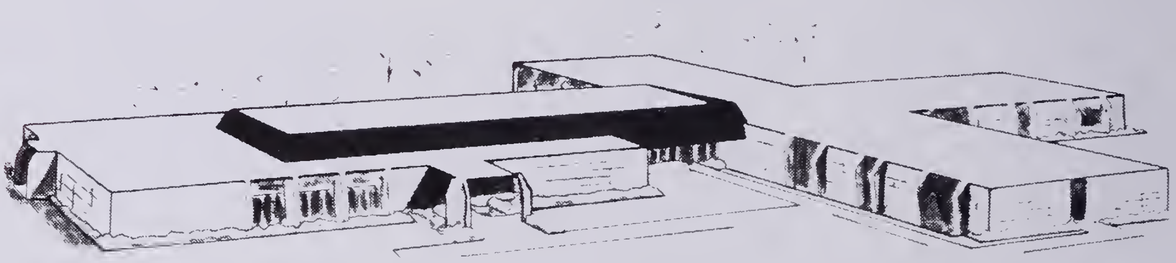

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*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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16th Annual

Michigan Conference on Maternal and Perinatal Health

March 30-31, 1977
Kalamazoo Hilton Inn, Kalamazoo

An excellent postgraduate opportunity is offered to all interested physicians, nurses and students through the 16th annual Michigan Conference on Maternal and Perinatal Health. Seven Category I CME credits will be awarded to physicians attending the conference, planned and sponsored by the MSMS Committee on CME Programming. Four major subject areas will be studied at the large and attractive Kalamazoo Hilton Inn. Plan now to attend.

— John V. Hartline, MD, Chairman

Wedns. afternoon, March 30

- Keynote address: Optimal Perinatal Care at the Community Level
- What starts labor?
- Clinical induction of labor
- Inhibition of labor

Thursday morning, March 31

- Pathophysiology of toxemia and detection in the gravid patient
- Clinical management of the antepartum and intrapartum pre-eclamptic patient
- The infant of the hypertensive mother
- Perinatal updates — Screening for hypothyroidism, and risks vs. benefits of clinical genetics

*****The Michigan Section, Nurses Association, ACOG, District V, will present a program Wednesday morning preceding the First Session. The Perinatal Association of Michigan will present a program Thursday afternoon following Perinatal Updates.**

MSGSS

Michigan Society of General Surgeons

PURPOSE

To give General Surgeons a socio-economic organization designed to aid them in their dealings with governmental and other third parties.

FUNCTIONS

To protect the public interest.

To protect the surgeon from intervention in performance of his professional duties.

To gather information regarding General Surgery, to inform ourselves and to provide a solid factual basis for dealings with others.

To join with similar organizations of other specialties to promote our common aims.

To make available to interested people or organizations, opinions and recommendations which could be helpful to planners of present or future programs where they relate to surgery.

To strive toward standardization and simplification of the paper work involved in the practice of surgery.

QUALIFICATIONS FOR MEMBERSHIP

Board cerficiation or eligibility in General Surgery, Fellowship in the American College of Surgeons, or recognition in the hospital in which one practices as a specialist in General Surgery.

For further information write Glenn E. Moore, MD, 1915 Lincoln Dr., Flint, Mich. 48503, Secretary-Tresurer.

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MONTHLY SURVEILLANCE REPORT

Cases of Certain Diseases
Reported to the Michigan Department of Public Health

For the five-week period ending Dec. 31, 1976

MICHIGAN
DEPARTMENT
OF PUBLIC
HEALTH

	1976 This 5-Week Period	1975 Same 5-Week Period	1976 Total To Above Date	1975 Total Same Date	Total Cases for 1975
Rubella	59	123	1,513	1,714	1,714*
Cong. Rubella Syndrome	1	0	2	1	1
Measles	157	91	6,139	3,253	3,253
Whooping Cough	3	10	70	98	98
Diphtheria	0	0	0	1	1
Mumps	352	1,016	5,507	9,979	9,979
Scarlet Fever & Strep Sore Throat	3,427	2,846	24,937	23,777	23,777
Tetanus	1	0	3	0	0
Poliomyelitis (paralytic)	0	0	1	0	0
Hepatitis	275	265	2,645	2,877	2,877
Salmonellosis (other than S. typhi)	85	68	889	864	864
Typhoid Fever (S. typhi)	1	1	10	10	10
Shigellosis	61	62	550	745	745
Aseptic Meningitis	14	19	163	280	280
Encephalitis	3	27	77	168	168
Meningococcic Meningitis	4	4	65	76	76
H. Influenza Meningitis	21	22	134	142	142
Tuberculosis	119	130	1,342	1,220	1,220
Syphilis	114	140	1,066	1,614	1,614
Gonorrhea	3,363	3,360	34,829	32,472	32,472

Information can be supplied by the local health department on local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

* corrected total

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In Memoriam

Abraham Bookstein, MD
Ferndale

Abraham Bookstein, MD, staff physician for nearly 50 years at Providence Hospital, Southfield, died at the age of 77 on Jan. 3. A graduate of the University of Michigan Medical School, Doctor Bookstein also was affiliated with Ardmore Hospital in Ferndale. He served in the military from 1942-1946.

Albert Boyajian, MD
Livonia

Albert Boyajian, MD, died Jan. 5 at the age of 54. Doctor Boyajian graduated from Wayne State University School of Medicine and was affiliated with Highland Park General Hospital. He served as a captain in the U.S. Air Force in 1954-1956.

Otto VanderVelde, MD
Holland

Holland Surgeon and general practitioner from 1924 until his retirement in 1971, Otto VanderVelde, MD, died Jan. 2 at the age of 86. Doctor VanderVelde graduated from Rush Medical College, Chicago and was affiliated with Holland City Hospital and Zeeland Community Hospital. He was past president of the Ottawa County Medical Society and a member of the International College of Surgeons. He was instrumental in establishing the Holland Area Guidance Clinic. He also founded Holland's first Red Cross Blood Bank and served as its medical director for many years.

William Frederick Weaver, MD
Farmington

William Frederick Weaver, MD, died Jan. 3 at the age of 45. A specialist in internal medicine, he was on the staffs of St. Mary's and Harper Hospitals, Detroit, and the Presbyterian Village Retirement Home in Redford Township. Doctor Weaver graduated from the Hahnemann Medical College of Philadelphia and was on the faculty of Wayne State University School of Medicine.

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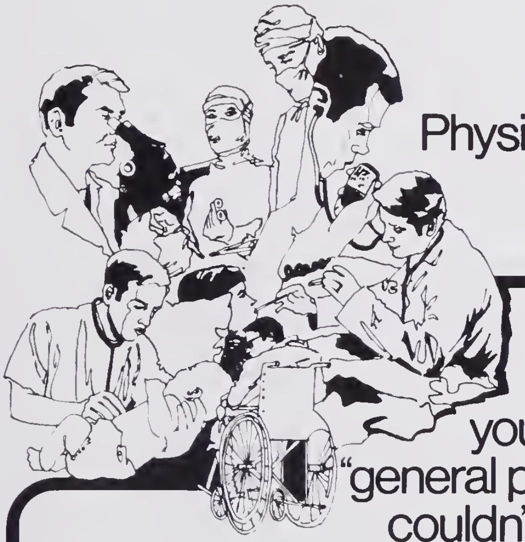

Classified

Psychiatrists for a modern-designed, progressive teaching and research psychiatric hospital of 600 beds. Programs involve Adult, Young Adult, community Mental Health Aftercare Clinics and Crisis Center services. Opportunity for energetic and creative psychiatrists to work in intensive diagnostic and treatment programs and for future promotion opportunities. LOCATION: Northville is a desirable residential suburban environment for quiet family living situated equidistant between Detroit and Ann Arbor, the latter being the seat of the University of Michigan Medical Center. High quality schools for children of all ages, extensive open-country recreational facilities, churches, opportunities for social activities. In addition, there are innumerable cultural and sports events in immediate surrounding communities such as symphonies, drama, art exhibits and professional and collegiate athletics.

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FOR FURTHER INFORMATION: Contact Fulvio M. Ferrari, M.D., Chief of Clinical Affairs, Northville State Hospital, Northville, Michigan 48167.

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PHYSICIAN WANTED: Vacancy for physician interested in mental retardation. This is a state institution caring for 1500 mentally retarded. Includes general hospital with ancillary services. Fringe benefits include medical and life insurance, sick leave, paid vacations, retirement, long term disability, etc. Michigan medical license required. Annual salary from $24,534 to $34,076 based on qualifications. Equal opportunity employer. Contact: Isak O. Berker, M.D., Medical Director, Oakdale Center for Developmental Disabilities, Lapeer, Michigan 48446.

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Attractive office space now available for rent in the Muskegon Mall area. Located in the Medical Arts Plaza, 315 West Clay Avenue, Muskegon, Michigan. Reasonable rates with many modern conveniences. For further information please contact Mrs. Westerman, (616) 726-3461 or after 5:00 p.m. (616) 725-7120.

EMERGENCY PHYSICIANS needed by established corporation in University town. Paid professional liability insurance, salary negotiable. Positions available July 1, 1977. Send C.V. to Mt. Pleasant Emergency Room Services, P.C. 2929 S. Isabella Road, Mt. Pleasant, Michigan 48858. Phone (517) 772-4767.

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STAFF CHILD PSYCHIATRIST — Board certified or eligible child psychiatrist with strong clinical background for child and adolescent community mental health outpatient clinic. Responsibilities include direct patient care; consultation to non-psychiatric staff; and clinical supervision of staff.

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DIRECTOR OF ADULT SERVICES — Board certified or eligible psychiatrist with strong administrative and clinical background to direct all services to mentally ill adults provided by county community mental health program. Responsibilities include administrative and clinical supervision of staff; planning, monitoring and evaluating contractual services of the board.

Services are primarily outpatient, day treatment and rehabilitation, part of a large, progressive C.M.H. program in a suburban county of about one million population.

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Potpourri

By Herbert A. Auer, Executive Editor

The AMA has criticized the recommendations of the Carnegie Council on Policy Studies in Higher Education to curb the development of more medical schools. AMA Senior Vice President C. William Ruhe, MD, has declared, "There still exists a shortage of physician services. We would not take a position like the Carnegie Council that the number of schools must be restricted."

* * *

Pennsylvania Governor Milton J. Shapp recently took the press to task by saying in part, "Unfortunately, no matter how sincere, clarifications rarely catch up with the falsifications that ruin reputations. So before harmful words are spread, editors should take action to avoid the need for public retractions."

* * *

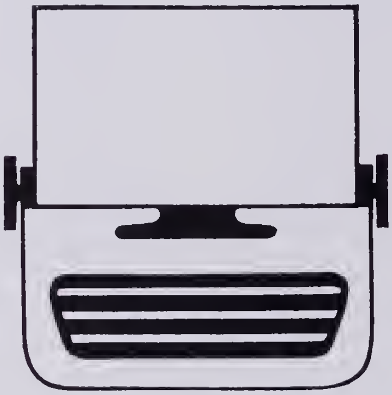
The U.S. Census Bureau has announced results of a survey of 130,000 oldsters asking them about their major concerns. Fear of crime led the list. The four worries mentioned the most were in this order: Crime, health, money, loneliness.

* * *

"Bureaucrats never change the course of the ship of state, they simply adjust the compass," so says James H. Boren, founder, president, and chairperson of the board of the International Association of Professional Bureaucrats, Washington, D.C. The group is a gimmick for Boren, who has a coat of arms with the motto, "When in doubt, mumble."

* * *

"Of course, we all belong to our County and State Medical Societies, and to the American Medical Association. These are things which are expected of every active and ethical physician. Does the question ever arise in our minds whether we are getting our money's worth for what we spend in dues in these various societies?



"If we are not getting anything, or very little, out of our medical societies, the reason is not far to seek: It is because we are putting nothing into them. You can't get anything out of a jug (or a medical society) that hasn't first had something put into it."

So said an MSMS Journal editorial 50 years ago.

* * *

The U.S. Chamber of Commerce's new efforts to organize a citizen's lobby to represent economic conservatives is being led by Jay Van Andel, of Michigan. Mr. Van Andel, chairman of Amway Corporation of Ada, near Grand Rapids, is chairman of the Citizens' Choice, set up as a separate organization from the Chamber.

* * *

Do you agree with a suggestion advanced by news commentator Edwin Newman, in his book *Strictly Speaking,* published by the Bobbs-Merrill Company? Newman asks:

> "Can a phrase be repealed? I have in mind 'Y'Know.' The prevalence of 'Y'Know' is one of the most far-reaching and depressing developments of our time, disfiguring conversation wherever you go."

* * *

The journal, *FDA Consumer,* has an interesting article along the line "To Serve Well and Not to Please: An FDA Dilemma." In part the article states, "The FDA is in a particularly difficult position when the science it must rely on says "maybe" while society is acting like a prosecuting attorney and demanding, "Answer 'yes' or 'no'."

* * *

Francis C. Lowell, MD, a Harvard allergy specialist who headed a panel on over-the-counter drugs, said there are between 35,000 and 50,000 cold remedies on the market with an annual sales volume of $735 million.

* * *

The *Lansing State Journal* carried a warm feature the other day about Maurice Reizen, MD, state public health director, after he had nearly won the Lansing YMCA Squash Tournament. Yes, he has regained his old form. Before he had both hip joints replaced at Mayo Clinic because of degenerative arthritis, in 1973, Doctor Reizen was a ranking player in Michigan. He resumed playing about a year and one half after surgery.

Michigan Medicine Contents

***Michigan Medicine*, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about contemporary issues and actions of the Michigan State Medical Society, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.**

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The Publication Committee of the MSMS Council is the editorial board of *Michigan Medicine* and advises the Council and the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

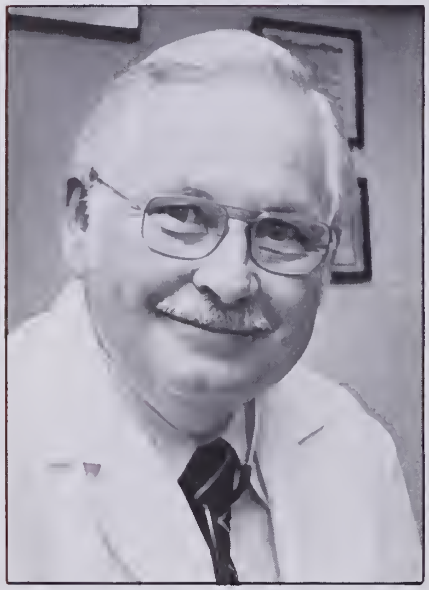
Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

In the next issue . . .

How Michigan med schools admit students today!

President's Page

MPMLC ready to take over from state fund



Robert M. Leitch, MD
MSMS President

What is the future of the Brown-McNeely Fund?

Several weeks ago, the Insurance Commissioner invited me to meet with him in Lansing to discuss professional liability in general and the future of the Brown-McNeely Fund in particular.

The Insurance Bureau still maintains the view that the Fund is temporary and the State should get out of the insurance business as soon as possible.

But, how soon is "soon?"

No one is willing or ready to say, though one requirement seems clear in any conversation with the Bureau experts or the authors of the Act.

This is that professional liability coverage must be available from commercial companies at a reasonable cost for all physicians in the Fund, with the possible exception of a very few who may be uninsurable.

This is a formidable requirement since its achievement is dependent upon the willingness of companies to assume new insureds using a surcharge system in lieu of the traditional underwriting procedures, and the financial capacity of the companies to assume new risks. The latter is subject to the actuarial decision of the Bureau.

The MSMS House of Delegates and The Council, in 1975, were seeking a solution to the availability problem first. Second, they were searching for long-range cost reduction solutions.

The Brown-McNeely Fund was an answer to availability for everyone needing coverage. But the thorn in this package was that all doctors who carry professional liability insurance, regardless of their insurance companies, are subject to assessments by the Fund should it at any time incur losses.

The MPMLC, Michigan Physicians Mutual Liability Company, has been the physicians' long term answer to availability and cost concern. It is doing well, insuring some 1,000 physicians with an annual premium income of $5,000,000.

Currently it is authorized by the Insurance Bureau to write 100,000/300,000 limits. Its actuaries, however, believe the MPMLC has the capacity to write 200,000/600,000 and the authority to do so has been sought by a formal filing, February 4, 1977.

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ANDROID-25 *vs.* Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy,* Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; + + = 50% improvement; + + + = 75% improvement. Placebo effectiveness was + or + + in 12.7% of trials. Android-25 elicited a +, + + or + + + response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg . Postpuberal cryptorchism, 30 mg **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly,* pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED**: 5, 10, 25 mg in bottles of 60, 250. Rx only

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Judicial Commission advises on alleged Medicaid abuse

The following statement was issued Jan. 26 to MSMS component medical societies by John M. Malone, MD, Chairman, MSMS Judicial Commission. It clarifies the Judicial Commission's stand on alleged abuses of the Medicaid program.

The Judicial Commission of MSMS is concerned about media accounts of alleged wrongdoing by physicians with regard to the Medicaid program, operation of clinical laboratories, etc. Recently, Commission members met with the president of the Michigan Medical Practice Board and the chairman of the MSMS liaison committee with the board to discuss informally how these problems, which concern all of us, might be alleviated.

Commission members recognize that component medical societies share these concerns, as they should, and that any effective program of medical discipline for the few physicians who dishonor the profession by improper conduct must take place at the local level. It is also recognized that most, if not all, component societies deal effectively with any members who act in an unethical manner.

Left to right, Commission members Clarence S. Livingood, MD, Grosse Pointe; Harold A. Machin, MD, Kalamazoo, and Chairman John M. Malone, MD, Farmington.

However, we urge your component medical society to be especially alert now for instances in which physicians appear to be engaging in unethical conduct, and to actively investigate these instances and take prompt and appropriate action. We also urge that documentation of your investigation of proven instances of unethical conduct, the conclusions you reach and the actions you take be forwarded to the Michigan Medical Practice Board and to the MSMS Judicial Commission, so that accurate information can be compiled on the extent of such abuses.

The Commission recognizes that, in many instances, the offending physician is not a member of the component medical society and thus, not subject to your disciplinary action. However, local societies sometimes are aware of illegal activities by non-members. Any knowledge of illegal activities on the part of any physician in your area should be forwarded to the Medical Practice Board so that it can conduct an investigation of the matter.

Improper conduct on the part of any physician reflects on us all. We urge that you join with the MSMS Judicial Commission and the Medical Practice Board in attempting to eliminate any unethical practices on the part of any physicians.

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MSMS study finds no basis for suing Medicaid program

There are no grounds for legal attack of the Michigan Medicaid program.

That is the finding of an MSMS-directed study of possible violations of federal and state law relative to Medicaid payments.

In September, 1976, The Council of MSMS directed the legal study. In order to obtain clearest objectivity in the study, an outside independent legal research firm was employed to conduct the study.

The Research Group, of Ann Arbor, MI, and Charlottesville, VA was commissioned to conduct the research and report to MSMS legal counsel.

The group reported back early in 1977. Following are answers to five key questions of the study:

Q. Under Michigan Medicaid, can doctors in different regions of the state be reimbursed at different rates for performance of the same services?

A. Yes. The Social Security Act specifically authorized use of regional variations in computing fee levels. ("Reasonable charges" for services to which individual practitioners are entitled under the program are tied to customary and prevailing fees in the locality where the services are rendered.)

Top priority of the MSMS Committee on Third Party Carriers currently is serious discussion of one region for determination of Michigan physicians' fees. The committee is led by Henry A. Kallet, MD, Jackson, head of table, and includes, from Doctor Kallet to right, Richard Gascoigne, MD, Adrian; Homer Smathers, MD, Detroit, and Thomas M. Flake, MD, Detroit.

Q. Under Michigan Medicaid, can health care institutions providing in-patient services be reimbursed at different rates than individual practitioners?

A. Yes. Social Security expressly authorizes this differential in payment rates because of peculiar financial problems faced by institutions providing health care services. Michigan law preserves this distinction; subsequent federal case law recognizes both an upper and lower payment limit for in-patient hospital services.

Q. Under Michigan Medicaid, are there any lower limits on the amount of reimbursement an individual practitioner may receive?

A. No lower limits on fee levels are set by Social Security, federal regulations thereunder, Michigan laws or case law. Federal regulations do specifically provide that the state agency may pay less than the upper limits for health care and services; attacks based upon various provisions *implying* lower limits have been unsuccessful.

Q. On January 1, 1976, an 11% reduction in maximum fee levels took effect pursuant to executive order issued by Governor Milliken. Was this 11% reduction valid under the Michigan and U.S. Constitutions?

A. Yes. The Governor acted within his state constitutional powers when he ordered the 11% reduction. Technical requirements for taking such action were satisfied. In addition, the U.S. Supreme Court has been extremely reluctant to find state assistance plans constitutionally defective. There are no decisions finding reductions in payment levels *per se* invalid under the U.S. Constitution.

Q. Was the 11% reduction in fee levels invalid because it was not approved by the Secretary of HEW?

A. Probably not, as Social Security requires approval of the secretary only when a state reduces "the scope or extent of the care and services provided." (It is not clear that this adjustment in payment levels affects the scope or extent of health care services available.)

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Claims-made insurance option supported by MSMS testimony

(The following is the statement of the Michigan State Medical Society to Michigan Commissioner of Insurance Thomas C. Jones, concerning proposed use of claims-made policy forms for professional, product, general, or governmental liability insurance. The statement was presented Feb. 15 by Thomas C. Payne, MD, assistant secretary, MSMS.)

The Michigan State Medical Society has a legitimate concern and a major interest in the broad problem of availability and cost of professional liability insurance. Physicians are dismayed at the rising costs and alarmed by the reduction in competition caused by many technical factors, one of which is that one of the major insurers has moved from occurrence to the claims-made policy form and is not now permitted to write in this state.

The Michigan State Medical Society has elected to comment directly on the allowance of claims-made policies. We have, in the past, encouraged medical malpractice insurance carriers to re-enter the Michigan market in order to assure continued availability of medical malpractice insurance.

There is not only a major concern over the high cost of professional liability insurance, but also over the limited availability of the insurance. We would hope that the re-emergence of interested insurance companies in the Michigan market (should claims-made policies be permitted), would help to contain costs and, in addition, provide competition for the carriers still writing this insurance in the state.

There has been considerable confusion and controversy surrounding the claims-made policy form. Much of this results from the misunderstanding of what a claims-made policy does or does not do.

It is important to remember at the outset that it does not solve the medical malpractice problem that presently exists in Michigan and the nation.

In early 1975, St. Paul Fire and Marine Insurance Company developed this new type of malpractice insurance. Our latest figures indicate that 34 states have approved claims-made insurance policies. To further support their claims-made approach, St. Paul reduced its premium for the final quarter of 1976 by an average of 18.3% in Minnesota, 21.2% in North Carolina, and 21.9% in Virginia.

Claims-made advantage

We readily see the primary advantage of the claims-made policy in that it minimizes the guesswork inherent in the present processing and pricing of malpractice policy. Clearly, the company will only have to estimate the number of 1976 claims that will be reported during 1977, a considerably easier task than determining in 1976 the experience four to five years in advance. The claims-made policy permits a company to annually adjust its rate level to reflect actual Michigan experience as it develops.

We do have a concern, however, that because a company is allowed this annual re-adjustment of rates, that this not be construed as an opportunity for the company to pass along costs for poor or inadequate defense or settlements of claims.

Recognizing that because the initial claims-made policy covers only the reported claims occurring the first year it is in effect, the first year claims-made premium will be substantially lower than that which will be charged for an occurrence policy covering the same year. Subsequent claims-made policies will cover both reported claims occurring during the current year and those occurring in prior years during which the physician is covered by that company's claims-made policy. Accordingly, the claims-made premium will increase each year it is renewed due to the continually increasing backlog of potential cases it covers.

We believe that although the premium of the basic claims-made policy could or should be 10-20% lower than adequate occurrence policy rates, a major unanswered question is what will the premium for tail coverage be? We remain concerned about the cost of the insurance after a physician's disability, or retirement.

MSMS requests

We must insist that the Commissioner require without fail that the tail coverage be automatically issued at a specific percentage of the physician's premium before approving the claims-made policy in Michigan.

Therefore, the Michigan State Medical Society strongly urges the Commissioner to require the following, should he permit claims-made coverage to be written in Michigan:

A. Require that reporting endorsements or tail coverage be automatically issued, at the option of the insured, upon cancellation or renewal of a claims-made policy.

B. Require that the formula for the reporting endorsements or tail coverage premium be a specific percentage of the average of a specified number of previous years' premiums.

C. Require that an option of paying for the reporting endorsement or tail coverage be accrued or paid over

(Continued on page 118)

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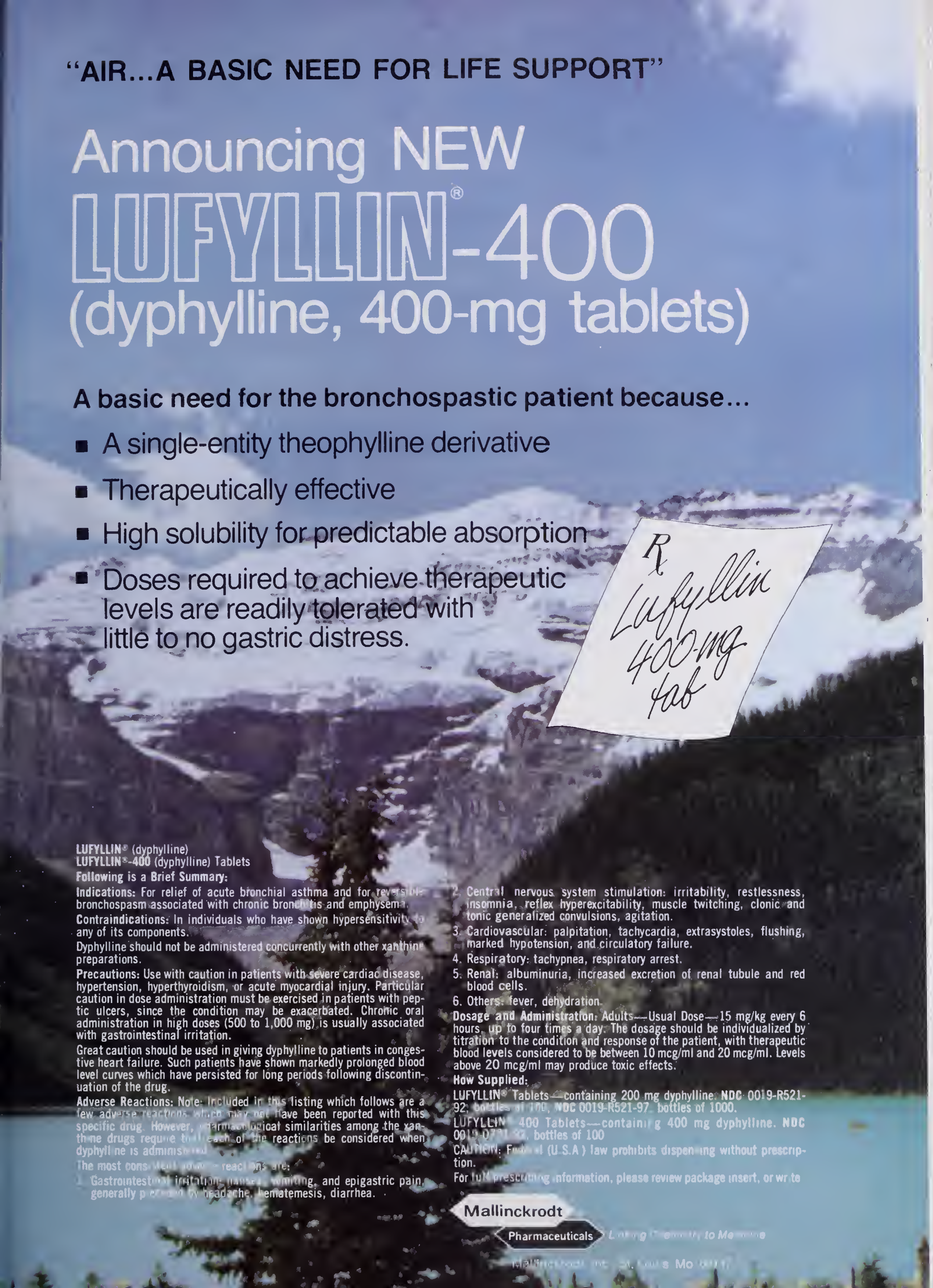

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Indications: For relief of acute bronchial asthma and for reversible bronchospasm associated with chronic bronchitis and emphysema.

Contraindications: In individuals who have shown hypersensitivity to any of its components.

Dyphylline should not be administered concurrently with other xanthine preparations.

Precautions: Use with caution in patients with severe cardiac disease, hypertension, hyperthyroidism, or acute myocardial injury. Particular caution in dose administration must be exercised in patients with peptic ulcers, since the condition may be exacerbated. Chronic oral administration in high doses (500 to 1,000 mg) is usually associated with gastrointestinal irritation.

Great caution should be used in giving dyphylline to patients in congestive heart failure. Such patients have shown markedly prolonged blood level curves which have persisted for long periods following discontinuation of the drug.

Adverse Reactions: Note: Included in this listing which follows are a few adverse reactions which may not have been reported with this specific drug. However, pharmacological similarities among the xanthine drugs require that each of the reactions be considered when dyphylline is administered.

The most consistent adverse reactions are:

1. Gastrointestinal irritation: nausea, vomiting, and epigastric pain, generally preceded by headache, hematemesis, diarrhea.
2. Central nervous system stimulation: irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions, agitation.
3. Cardiovascular: palpitation, tachycardia, extrasystoles, flushing, marked hypotension, and circulatory failure.
4. Respiratory: tachypnea, respiratory arrest.
5. Renal: albuminuria, increased excretion of renal tubule and red blood cells.
6. Others: fever, dehydration.

Dosage and Administration: Adults—Usual Dose—15 mg/kg every 6 hours, up to four times a day. The dosage should be individualized by titration to the condition and response of the patient, with therapeutic blood levels considered to be between 10 mcg/ml and 20 mcg/ml. Levels above 20 mcg/ml may produce toxic effects.

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Legal fees insurance out; but there are some options

Michigan physicians cannot obtain insurance specifically for legal fees in this state. They can, however, obtain coverage for $10,000/30,000 at a reasonable rate, which would provide not only that liability limit, but also provide legal service without extra charge.

That is the gist of information provided to the MSMS Council following the 1976 MSMS House of Delegates' resolution that MSMS investigate the possibility of legal insurance or other monetary protection for legal costs, and if feasible, encourage or aid in the development of such insurance.

Class V physicians, however, the Council advised, might prefer self-insurance to the high premiums of the 10/30 insurance.

House of Delegates' Resolution 76A-70 noted that "it is becoming evident many Michigan physicians are practicing without insurance; that, if sued, those physicians would require legal defense; the certainty of legal defense would help discourage malpractice litigation, and that insurance to provide legal defense would be reasonable in cost compared to complete liability insurance."

T. E. Linham, Medical Protective Company vice president, reported that Medical Protective "does have a wide selection of limits available to our policyholders beginning with 10/30, on up through the maximum currently being offered, 100/300.

"In Area I, which includes Wayne, Genesee, Macomb and Oakland counties, our annual rates for a 10/30 policy range from $564 for Class I physicians up to $3,518 for Class V physicians," said Mr. Linham in reply to an MSMS Council query. "The comparable 100/300 rates are $1,383 and $9,156, respectively.

"Within our maximum," Mr. Linham continued, "a physician may select from any number of limit options during his current policy term or at renewal. However, our capacity for new business is quite limited at the present time and we are not soliciting new accounts. Hopefully, this situation will not continue indefinitely."

The MSMS Council suggested that physicians take the option of investing the $3,500 per year in a special account, which in three years would build up equity in the amount of the policy. In other words, the Class V physician would be self-insured and could afford a considerable amount of legal advice.

But Mr. Linham adds that the Medical Protective maximum loss payment is $30,000 per year, with a limit of $10,000 to be paid out in any one case. In addition, each MP policy provides unlimited defense costs.

Thus, the Michigan physician has several options in planning for his protection from legal fees.

MSMS TESTIMONY/*Continued*

a multiple year period that the claims-made policy is in force.

D. Require that there be a guarantee of continued availability of the claims-made policy in Michigan for a specific number of years.

Additional alternative

While I see no reason for a wholesale jump to claims-made policies by doctors long accustomed to occurrence-type policies, I believe a claims-made option including the features just mentioned would offer Michigan doctors an additional alternative to insurance availability, assuming there are companies willing to write such a coverage.

A major task of any such move will be in educating the potential insureds to the mechanism of this insurance.

While some individual doctors may have serious reservations about claims-made insurance, the Michigan State Medical Society, as a matter of policy, supports the concept of a pluralistic system. We believe in a free and open marketplace. While I, or any doctor, may have a particular preference for one type of insurance policy over another, I believe we would all support the concept of choice and availability.

If claims-made truly increases the options by making insurance available at competitive prices for comparable coverage, then making it available might be desirable.

Please note that I am not speaking to any technical aspects of this type of insurance. I am only responding to the basic philosophy of reasonable cost and availability.

I respectfully request the Commissioner to give this matter very careful study, and I pledge the cooperation and the resources of the Michigan State Medical Society to assist in that pursuit.

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to lower
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without
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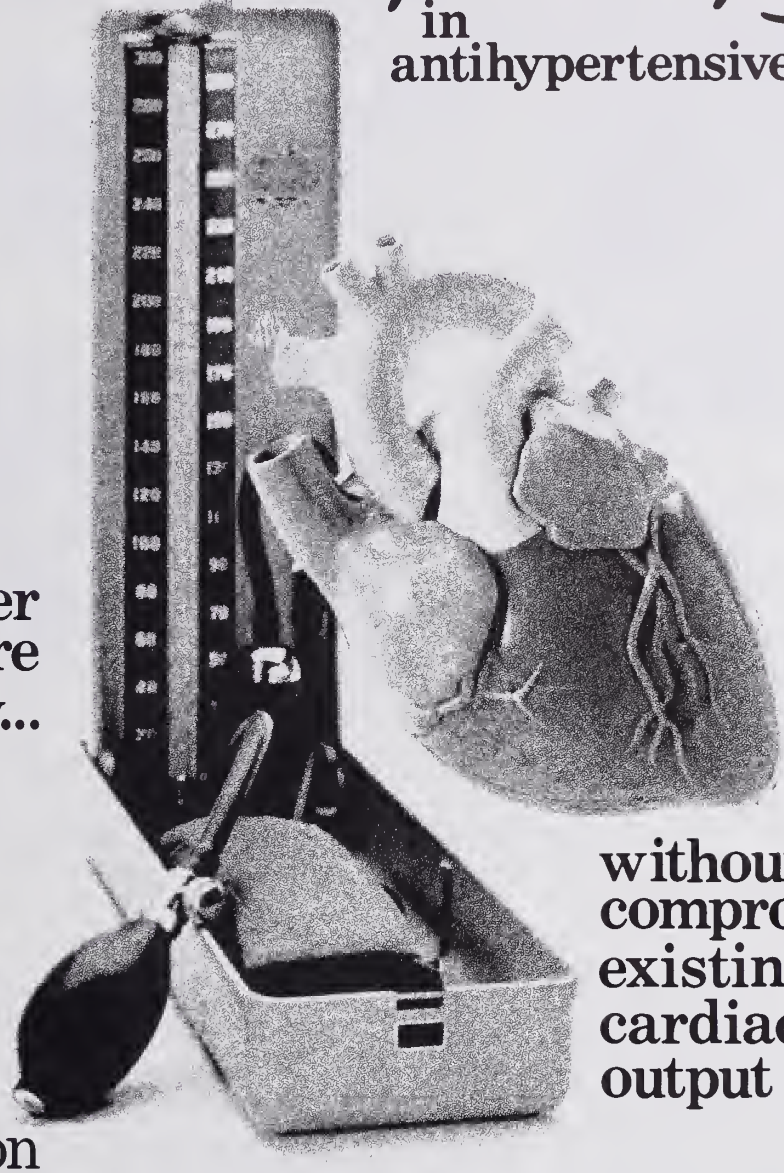

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It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

For a brief summary of prescribing information, please see following page.

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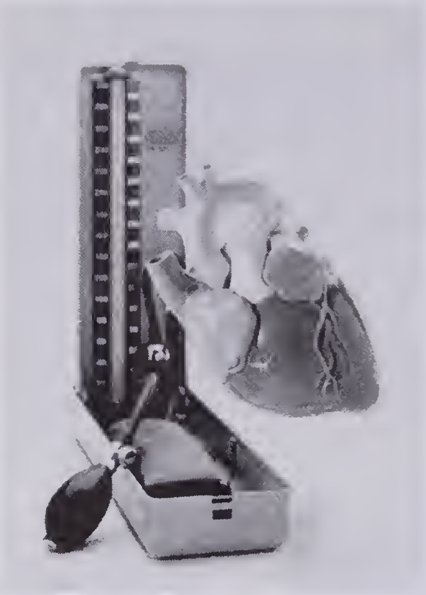

in hypertension

ALDOMET®

(METHYLDOPA|MSD)

helps lower
blood pressure
effectively...
usually with no
direct effect on
cardiac function–
cardiac output is
usually maintained

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressors. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by this procedure.

Adverse Reactions: *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decreased mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

Cardiovascular: Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease daily dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

Gastrointestinal: Nausea, vomiting, distention, constipation, flatus, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

Hepatic: Abnormal liver function tests, jaundice, liver disorders.

Hematologic: Positive Coombs test, hemolytic anemia. Leukopenia, granulocytopenia, thrombocytopenia.

Allergic: Drug-related fever, myocarditis.

Other: Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limited to 500 mg daily when given with antihypertensives other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

How Supplied: Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486 J6AM07(707)

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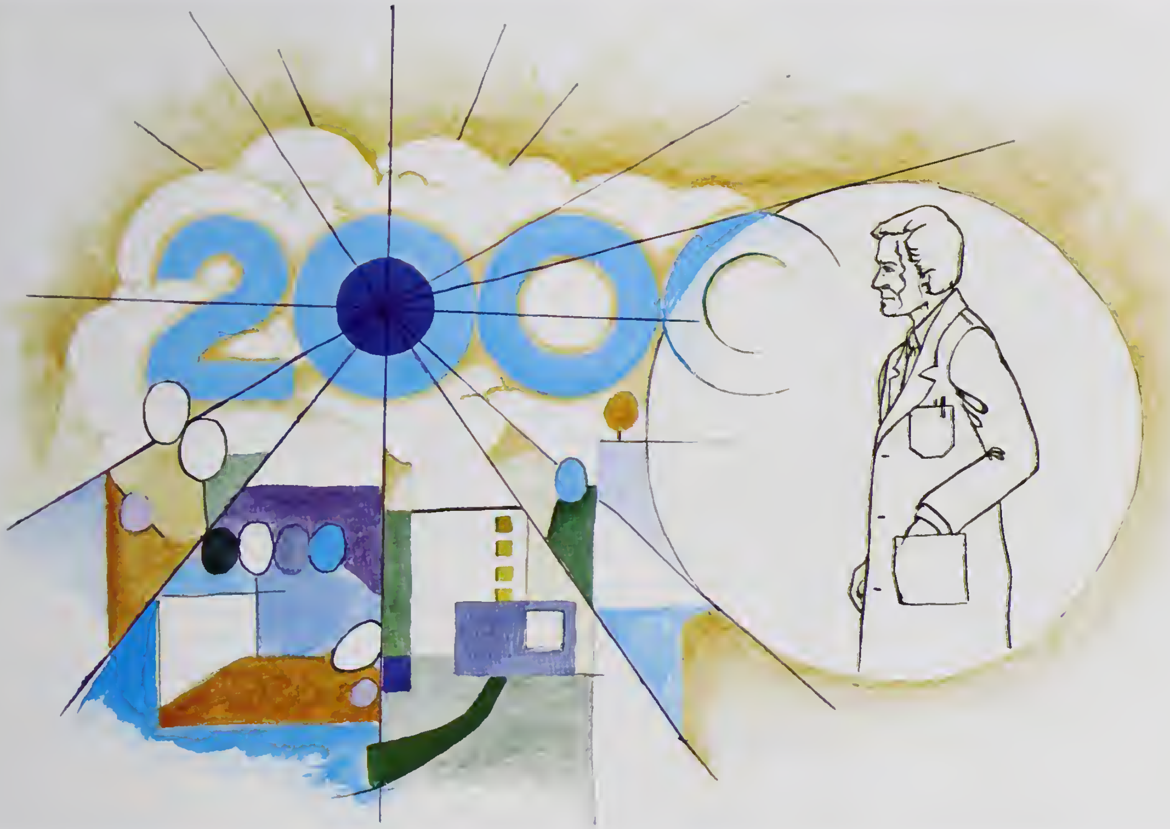

Medicine in the Year 2000; Some MSMS members look ahead

By John B. Bryan, MD
Royal Oak

What will be the "state of medicine" in 2000 AD? So, I take another long drag on my pipe and watch the smoke billow out into the air before me. And it's just as hazy as any crystal ball wherein I've ever tried to find a preview of the future.

I recall wondering 27 years ago, when I came to Michigan for my residency in medicine at Henry Ford Hospital, what great changes could be expected in medicine by 2000 AD. At that time, I had vowed I'd survive until then to see firsthand and a small cadre of convivial Navy revellers from Pearl Harbor days had pledged a "get-together" on New Year's Eve of 2000 AD to start "the final party" till the last man went down.

That's my personal goal. But more importantly, I believe the art and science of medical care still shall be based on the contract of the patient-physician relationship. I firmly believe the American patient shall continue to demand his right to free choice of the physician or surgeon who shall administer to him for his ills. The "contract" may indeed have a different method of reimbursing the doctor for his efforts, and my feeling is that it will probably be by "prepayment mechanism," the doctor being paid an adequate salary, plus the standard fringe benefits of "an executive" so that his economic station shall be amongst the highest in the country. It may take the efforts of physicians' "guilds" to guarantee and continue this.

I think today, particularly in the

What will it be like to practice medicine in the year 2000?

It's an interesting question that makes the thoughtful envision great challenges, new opportunities and sometimes disquieting developments.

But, regardless, there will be change.

Michigan Medicine *put the question to a number of medical care experts in our state, to allow them the opportunity to formulate their own medical future and describe it to Michigan physicians. We invite you to "dream along" with our visionaries.*

Doctor Bryan is an internist.

YEAR 2000/*Continued*

major metropolitan areas and their fine teaching hospitals, there is more than a tendency for specialists in all fields of medicine to be full-time employees of the medical center. This is not all bad.

I see an arrangement of primary care stations or service bases, with some secondary facilities between the two, as the best way to provide care in 2000 AD in direct proportion to the needs of patients and capabilities of each facility. Since working with, training and delegating medical chores to fine young Navy corpsmen or corpswaves I've also felt that we in civilian life could make better use of our young who wish to serve in an ancillary role. I see it happening now in my hospital's fine emergency center, in the X-ray department, surgical suites and on the wards, where the new "physician's assistant" is "caring for" patients, in the fullest sense. I envision more and more of these persons providing a greater share of "routine care" to the patient at the turn of the next century.

I believe the magic balance of the number of available physicians for

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The post-physician era?

1980 — Unrestricted medical license granted only after completion of residency. Ombudsmen widely used in hospitals and clinics.

1985 — Virtual obsolescence of the general practitioner.

1990 — Wide use of professional nurses to deliver primary care.

2015 — Virtual cessation of MDs providing clinical services except for surgery.

Are you intrigued?

That is the timetable for the near future as constructed by physician-author Jerrold Maxmen, MD. He has published a new book, "The Post-Physician Era," in which he predicts doctors will be obsolete in 50 years, replaced by computers and a new type of health care professional called: "the medic."

"Three major capabilities are required for logical medical decisions — *objectivity, probability, and memory,"* says Maxmen. And the computer can outperform the doctor in every one of them. Computers are always rational, while doctors "can be unduly influenced by their feelings and can make serious errors in judgment." While a physician, in assessing the probability that a patient's symptoms mean that he has a particular disease, can rely only on his own knowledge and experience, a computer of the future, because of its gigantic storage capacity, could have access to "the collective wisdom of all physicians." The doctor's memory is limited; the computer *never* forgets.

Maxmen goes on to dispose of the criticism that a physician, by making "intuitive leaps," has an advantage in diagnosing a new patient from "scratch." "A study was conducted in which the Cornell Medical Index, a 195-item questionnaire, was administered to 5,929 consecutively hospitalized patients. A machine analyzed the questionnaires to yield a diagnosis from among 60 possibilities. The result of this investigation revealed that the derived diagnoses were slightly more accurate than those rendered by physicians," Maxmen reveals.

With computers taking over the technical functions of the present-day physician, a new breed of health-care professionals will be trained to assume the supportive and psychotherapeutic functions. Because of this reduced burden, Maxmen says, "the medic will not have to possess a basic understanding of health and disease concepts." The medic's training will take only 12-18 months, compared to eight years for modern doctors. "Interpersonal talents will replace scientific sophistication as the major admission criterion." Medics will be selected on the basis of their capacity to "empathize with, be sensitive to and be tolerant of people with physical and emotional disorders."

The communications revolution will play a major role in the provision of medical services in the future, Maxmen predicts. "The widespread availability of videotelephones, IATV [interactive television] and computer terminals within the home may allow patients to receive a large proportion of their medical care without having to travel to a hospital, clinic, or office."

Maxmen also devotes several chapters to speculation about future breakthroughs in biomedicine. "Just as medical computers underscore the limits of physicians," he predicts, "so too will future biomedical innovations highlight humanity's biological deficiencies. The anticipated ability to manipulate genetic material, create an artificial placenta, and clone superior beings illustrates that technology could improve upon man's reproductive processes. In the future, synthetic organs will be able to outperform natural ones. Eventually, human-machine chimeras may be able to exceed man's physical powers, emotional functions, and intellectual capacities. These innovations may seem frightening because of their potential dehumanizing effect and impact upon man's evolutionary future. Condemning these innovations, however, can neither sweep away the fact of their possible development nor allow us to avoid recognizing the biological limitations of our species."

Doctor Bryan

all Americans in their communities shall never be met and certainly not by 2000 AD. Physicians, I believe, shall demand to continue to have the right to choose where they shall live and whom they will serve. And no effort by governmental coercion shall succeed in supplying every hamlet and town in the US with its needed medical personnel.

More care by EMS

I think outposts of physician's assistants, nurse clinicians and allied health persons will fill many voids. Newer forms of rapid transportation, probably by air, will get the critical problems to the right medical center.

And I see in 23 years a very sophisticated emergency medical services system serving communities as our present police and fire departments do. These teams will do the CPR treatment of cardiac problems, pneumo thorax, suffocation, drownings, treatment of insulin reactions, diabetic ketoacidosis, adrenal insufficiency, asthmatic attacks, epilepsy in status and many other acute problems en route to the hospital or at the scene. Perhaps their greatest role may be superb first aid.

This all means that the RESPONSIBILITY for medical care will be partially wrested from the hands of physicians and surgeons until such teams transfer care at the medical center. I see doctors allowing this. And, I see them doing it willingly, using sophisticated communications systems to "talk in" the team as the controller in the tower at an airfield does pilots of planes.

By 2000 AD, I think the vital need for such use of allied health professionals will obviate the litiginous climate of today and such teamwork will recapture the esteem of the populace for the medical profession. The American of 2000 AD should "have it made" so far as his medical emergency needs are concerned and I think he or she will be much more knowledgeable about his body, health needs and emergencies. I think the patient will be paying quite a price for this elaborate system through payroll deductions for "premiums" to insurance carriers, taxes at various levels. Not 8% of the dollar shall go to provide this care, but more likely 30%.

And I believe the "cottage industry" of the many individual offices with the traditional examining and consultation rooms of the physician shall be here in 2000 AD. For there is no other way I know of to provide that intimate inter-relationship necessary for treating human ills. "The primary care physician" may have to relinquish care of the patient during any hospitalization and for special procedures and therapy, but still have to serve that patient on return home. Rapid transmission and translation of information to the physician from the center will be mandatory and possibly via office computer terminals to allow smooth continuation of care.

Oh, yes, all this is going to be very expensive, including "guild dues," because I see a strengthening of the role of organized medicine in the future of every physician's life by 2000 AD.

The hardest thing for me to fathom at this moment, though, is the relationship of the hospital, as represented by its trustees, administration (lay and professional), and the "voluntary staff." I sense there shall be some clashes between these groups at many hospitals and I cannot guess what manner of hierarchy shall rule the hospitals of 2000 AD. I fear there shall be a "we-they" relationship of serious import and organized medicine, as the "guild" for the staff physicians may have to "negotiate" contracts for salaries, fringe benefits, appointment titles, privileges and responsibilities.

I'm convinced that certification, re-certification and similar recognition of expertise and continued growth in one's area of interest shall be necessary for maneuvering for "position" on hospital staffs (this comment is mainly for the younger physicians who may be wondering about the importance of such "investment" in training and preparation and "taking the boards" in one's chosen area of service to the community.)

1950 provides clues

So — on to 2000 AD. If the speed of passage of the last 23 years is an indicator, it's certain the next will go even faster and we shall soon see how accurate my prognostications really be. Two things seem certain — (1) today is yesterday's tomorrow and (2) it is human nature for us to keep repeating our best efforts as well as errors, time after time. A glimpse of 2000 AD should be obtained by a look back at 1950. This would fit in beautifully with the 50-year Kondratieff Wave, named after an otherwise obscure Russian economist, who, in the 1920's, first studied 50-year cycles in industrial countries. He concluded correctly that there would be difficult times for the capital countries in the 1930's, but he made a strategic blunder for a Russian by suggesting that the capitalist countries *would* survive. The Soviet government's reaction was predictable. He spent the rest of his life in Siberia, and his experience serves as a constant object lesson with regard to making forecasts that are unpopular with the powers that be.

Government control can't be substituted for self control

By John M. Dorsey, MD
Detroit

The introduction of the force of my American Government, hence American Politics, into the profession of medicine is the most shocking event in American medical history, nearly forswearing, as it does, the hard-won right of each citizen to religious liberty. Although there may be some greater health risk in store for my fellow citizen, I cannot at present conceive of it.

Nevertheless, I see this illusion (alien control of the physician) as *necessarily* evolving out of insufficient knowledge about the indescribable difficulties daily experienced by the health educator and by each MD particularly. It is a matter of precious time (heartbeats) until most trying experience must teach even the least informed third-party objector that medical help, like all help, is self-help and that each citizen's health needs cannot be met by any delivery system other than that of his own individual choosing.

Too easy to be critical

It is too easy for me as physician or government agent to be blindly critical of whatever I can mean by political governance or by medical practice. Entirely too little is known about American citizenship. I am not born an American citizen in the full meaning of that designation, any more than I am born a college graduate merely because I am born able to become one provided that I work at it enough. Entirely too little also is known about the difficulty and danger in the study and practice of medicine. Only the individual practitioner can really know or care much that his are the largest responsibilities of a servant and that his profession exacts the highest death-rate of all.

My governmental representative already sees the sensible wisdom in leaving each citizen's control of his religion to his own soul, and in due time must heed the telltale folly in trying to deprive any citizen of his *moral* responsibility for his own health care. Responsibility cannot apply in any sense anywhere but to a specifically given *person.* So-called "state" or "government" responsibility for anyone or anything is a total impossibility.

What is needed most

I feel that I do know what will be needed most in my medical practice during the last quarter of this century, namely a Thomas Jefferson who can enact, and a Roger Baldwin who can activate, a civil right declaring that so-called federal or state regulation of medicine must prove equally as dangerous to the preservation of American union as would be imposed federal or state religion.

The idea that a hypertrophied personification such as "Government" can seem to hold itself responsible for the health of each of its citizens is perhaps the most expensive and expansive example imaginable of a man's seeming to become subject to one of his own ideas. Such seeming alien control is the source of all mental trouble and already everybody's (unrecognized) number one public health concern.

I have already lived through three quarter-century intervals and learned from self-experience, my only possible teacher, some control of my emotions so that I may favor sober observation of the facts of my history accurately accounting for my present condition. Above all I have learned that the efficacy of hope has ever been the physician's medical mainstay.

Doctor Dorsey

We get medicine deserved

I hope desperately that, before 2000 A.D., my government official shall have convinced himself of the futility of trying to substitute his abstraction named "government control" for his own self-reliant *self control.* I can only hope and trust that he must recognize the necessary localism of human individuality inherent in all *biologically adequate* appreciation for the true nature of the whole patient and for the true nature of the whole physician.

Other than in the form of disciplined self control, government is, as George Washington described it cautiously in his farewell address to his troops, namely, "a force, like fire, it is a dangerous servant and a fearful master." It is a dreadful succedaneum for the necessary basis of all medical practice, specifically, full and unremitting attention to the ineluctable fact of the individual variant.

I offer at once a stirring and stabilizing thought: As long as his Constitution lasts, nothing will or can prevent the American citizen from getting the precise kind of medical service he deserves.

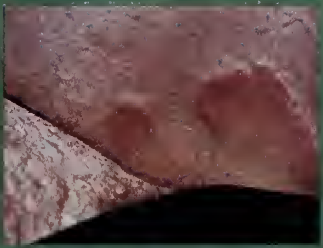
(Continued on page 132)

Doctor Dorsey is university professor emeritus at Wayne State University.

When Griseofulvin is indicated...

TINEA PEDIS*

TINEA UNGUIUM*


TINEA CRURIS*

TINEA CAPITIS*

*Also *Tinea barbae* and *Tinea corporis* when caused by fungi from genera known to be sensitive to griseofulvin.

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(griseofulvin ultramicrosize)

Tablets 125 mg

offers effective therapy with 1/2 the dose.†

- Can be taken on an empty stomach
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†250 mg of Gris-PEG® provides plasma levels equivalent to those obtained with 500 mg microsize griseofulvin. This improved absorption permits the oral intake of half as much griseofulvin but there is no evidence, at this time, that this confers any significant clinical difference in regard to safety or efficacy.

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Gris-PEG®

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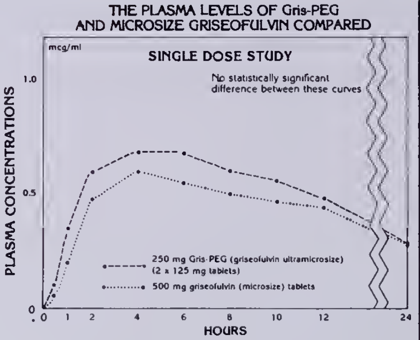
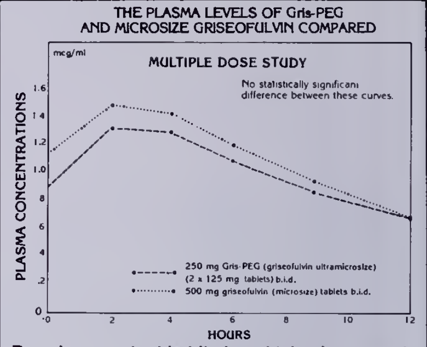
The ½ dose griseofulvin.

THE PLASMA LEVELS OF Gris-PEG AND MICROSIZE GRISEOFULVIN COMPARED



Based on a single dose double-blind bioavailability study conducted in 24 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels. There is no significant difference between peak plasma levels, times to peak, and areas under the curve. Gas chromatographic assay.

THE PLASMA LEVELS OF Gris-PEG AND MICROSIZE GRISEOFULVIN COMPARED



Based on a double-blind multiple dose steady state crossover bioavailability study conducted in 17 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels obtained on days 9, 11 and 13. There is no significant difference between times to peak, peak plasma levels, and areas under the curve. Gas chromatographic assay.

DESCRIPTION

Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION

Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum*, *Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsized griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy.

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS

Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections.

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis; ringworm of the nails)

when caused by one or more of the following genera of fungi:

Trichophyton rubrum
Trichophyton tonsurens
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleini
Microsporum audouini
Microsporum canis
Microsporum gypseum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is not effective in the following:

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS

This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS

Prophylactic Usage: Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5-2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy: The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress.

Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS

Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists; however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS

When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSAGE AND ADMINISTRATION

Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6 weeks; *tinea corporis*, 2 to 4 weeks; *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months; toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsized), USP (see ACTION Human Pharmacology).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis, the following dosage schedule for children is suggested:

Children weighing over 25 kilograms (approximately 50 pounds)—125 mg to 250 mg daily.

Children weighing 15-25 kilograms (approximately 30-50 pounds)—62.5 mg to 125 mg daily.

Children 2 years of age and younger—dosage has not been established.

Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED

Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin (microsize) tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsized griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsized griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.

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All courses are approved by the AMA Council on Continuing Physician Education for Category 1 credit toward an AMA Physician's Recognition Award. A syllabi written by medical school faculties is provided with every course.

Specific information on course location, fees, academic program, faculty, and hotel reservations will be available approximately 2 months before each course date. Please write to address below at that time stating your selection(s). Print name, address, and office phone number.

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Tulsa, Oklahoma	January 22-23
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*Lake Tahoe, Nevada	February 11-13
Denver, Colorado	February 19-20
*Tarpon Springs, Florida	March 4-6
Detroit (Southfield), Michigan	March 26-27
New York (Westchester), New York	April 16-17
Houston, Texas	May 15
Hartford, Connecticut	September 10-11
*Lake of the Ozarks, Missouri	September 16-18
Chicago, Illinois	September 24-25
*Hot Springs (Homestead), Virginia	Sept. 30-Oct. 2
*Huron, Ohio	October 7-9
*Honolulu, Hawaii	Oct. 30-Nov. 4
Hershey, Pennsylvania	November 18-19

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San Francisco, California	June 18-22

AMA's Winter Scientific Meeting

Miami Beach, Florida	December 10-13

AMA Spokesmanship Seminars

Chicago, Illinois (Marriott O'Hare Hotel)	August 13-14 November 12-13

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*Courses end at midday for recreation activities

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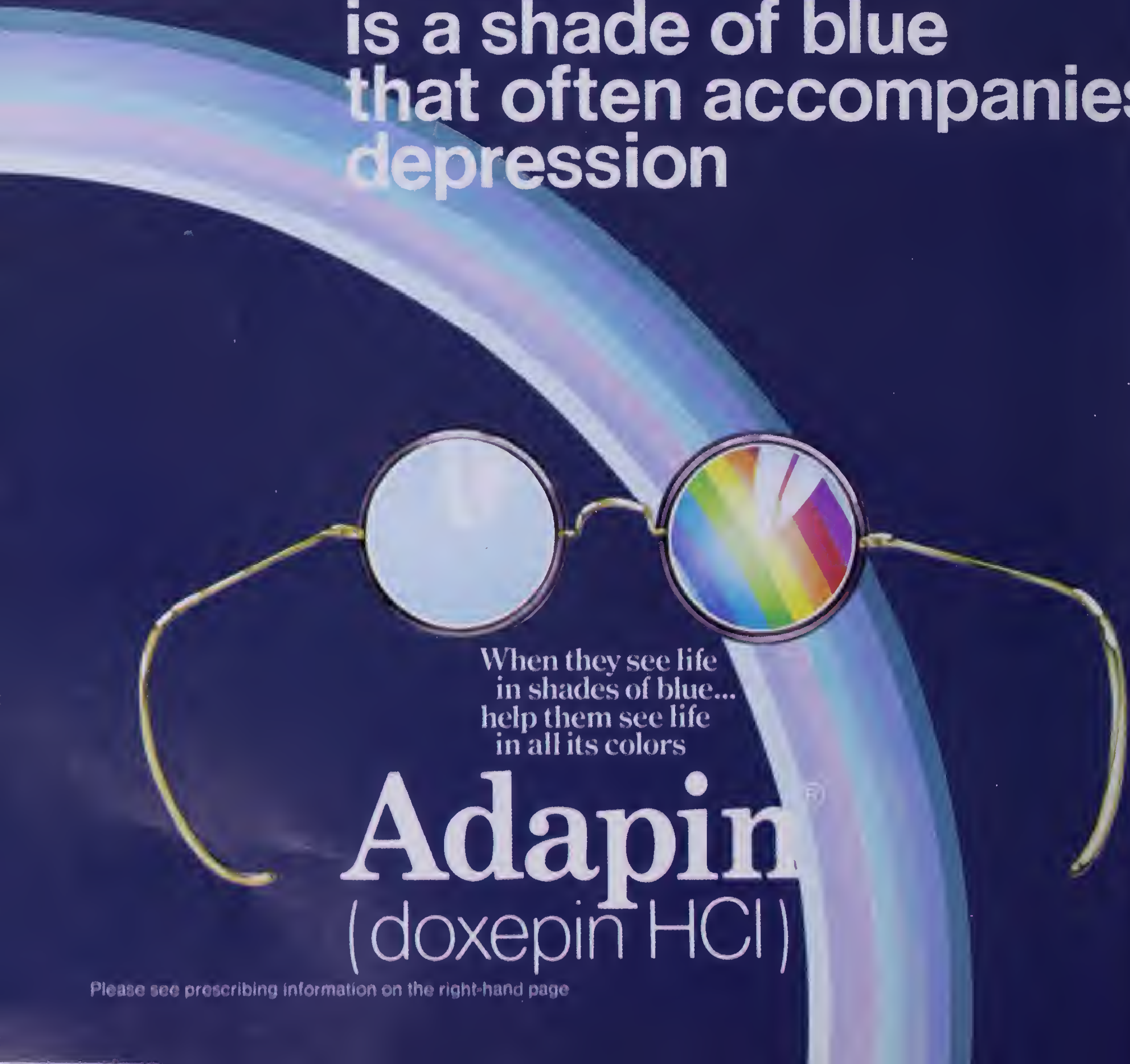
Insomnia is a shade of blue that often accompanies depression



When they see life
in shades of blue...
help them see life
in all its colors

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(doxepin HCl)

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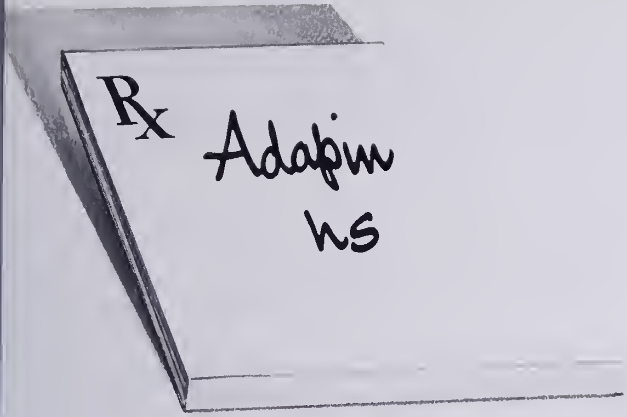

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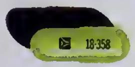

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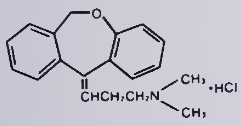

ACTIONS

Adapin has a variety of pharmacological actions with its predominant action on the central nervous system. While its mechanism of action is not known, studies have demonstrated that it is neither a monoamine oxidase inhibitor nor a primary stimulant of the central nervous system.

INDICATIONS

In controlled clinical evaluations, **Adapin** has shown marked antianxiety and significant antidepressant effects. **Adapin** has been found to be well tolerated even in elderly patients.

Adapin is indicated for the treatment of patients with:

1. Psychoneurotic anxiety and/or depressive reactions.
2. Mixed symptoms of anxiety and depression.
3. Anxiety and/or depression associated with alcoholism.
4. Anxiety associated with organic disease.
5. Psychotic depressive disorders including involutional depression and manic-depressive reactions.

Target symptoms of psychoneurosis that respond particularly well to **Adapin** include: anxiety, tension, depression, somatic symptoms and concerns, insomnia, guilt, lack of energy, fear, apprehension and worry.

Because **Adapin** provides antidepressant as well as antianxiety effects, it is of particular value in patients in whom anxiety masks depression. Patients who have not responded to other antianxiety or antidepressant drugs may benefit from **Adapin.**

In a large series of patients systematically observed for withdrawal symptoms, none were reported—a finding which is consistent with the virtual absence of euphoria as a side effect and the lack of addictive potential characteristic of this type of chemical compound.

CONTRAINDICATIONS

Because **Adapin** has an anticholinergic effect, it is contraindicated in patients with glaucoma or a tendency toward urinary retention.

Use of **Adapin** is contraindicated in patients who have been found hypersensitive to it.

WARNINGS

Usage in Pregnancy—Adapin has not been evaluated in pregnant patients. Therefore, it should not be used during pregnancy unless, in the judgment of the physician, it is essential to the welfare of the patient.

In animal reproduction studies of **Adapin (doxepin hydrochloride),** gross and microscopic examination of the offspring gave no evidence of drug-related teratogenic effect. Following doses of up to 25 mg./kg./day for 8 to 9 months, no changes were observed in the number of live births, litter size, or lactation. A decreased rate of conception was observed when male rats were given 25 mg./kg./day for prolonged periods—an effect which has occurred with other psychotropic drugs and has been attributed to drug effect on the central and/or autonomic nervous systems.

Usage in Children—The use of **Adapin** in children under 12 years of age is not recommended, because safe conditions for its use have not been established.

MAO Inhibitors—Serious side effects and even death have been reported following the concomitant use of certain drugs with MAO inhibitors. Therefore, MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with **Adapin.** The exact length of time may vary and is dependent upon the particular MAO inhibitor being used, the length of time it has been administered, and the dosage involved.

PRECAUTIONS

Drowsiness may occur with **Adapin**; therefore, patients should be warned of its possible occurrence and cautioned against driving a motor vehicle or operating hazardous machinery while taking the drug.

Patients should also be cautioned that the effects of alcoholic beverages may be increased.

Since suicide is an inherent risk in depressed patients and remains a risk through the initial phases of improvement, depressed patients should be closely supervised.

Although **Adapin** has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Compounds structurally related to **Adapin** can block the effects of guanethidine and similarly acting compounds. However, at the usual clinical dosages, 75 mg. to 150 mg. per day, **Adapin** has been given concomitantly with guanethidine without blocking its antihypertensive effect. But at dosages of 300 mg. per day or higher, **Adapin** has exerted a significant blocking effect.

Adapin, like other structurally related psychotropic drugs, potentiates norepinephrine response in animals. But this effect has not been observed with **Adapin** in humans, which is in accord with the low incidence of tachycardia reported clinically.

ADVERSE REACTIONS

Anticholinergic Effects: Dry mouth, blurred vision and constipation have been reported. These are usually mild, and often subside as therapy is continued or dosage reduced.

Central Nervous System Effects: Drowsiness has been observed. It usually occurs early in the course of therapy and tends to subside as therapy continues. (See Dosage and Administration section.)

Cardiovascular Effects: Tachycardia and hypotension have been reported infrequently.

Other infrequently reported adverse effects include extrapyramidal symptoms, gastrointestinal reactions, secretory effects (such as increased sweating), weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash, and pruritus.

DOSAGE AND ADMINISTRATION

In most patients with mild to moderate anxiety and/or depression: 10 mg. to 25 mg. t.i.d. to start. A starting dosage of 10 mg. t.i.d. for a period of four days may reduce the initial drowsiness experienced by some patients, and may be tried in cases where drowsiness is clinically undesirable. Decrease or increase the dosage at appropriate intervals according to individual response. Usual optimum dosage is 75 mg. to 150 mg. per day.

In some patients with mild symptomatology or emotional symptoms accompanying organic disease, dosage as low as 25 mg. to 50 mg. per day has provided effective control.

In more severe anxiety and/or depression: 50 mg. t.i.d. may be required to start—if necessary, gradually increase to 300 mg. per day. Additional effectiveness is rarely obtained by exceeding 300 mg. per day.

Although optimal antidepressant response may not be evident for two to three weeks, antianxiety activity is rapidly apparent.

OVERDOSAGE

Symptoms—An increase of any of the reported adverse reactions, primarily excessive sedation and anticholinergic effects such as blurred vision and dry mouth. Other effects may be: pronounced tachycardia, hypotension and extrapyramidal symptoms.

Treatment—Essentially symptomatic; supportive therapy in the case of hypotension and excessive sedation.

HOW SUPPLIED

Each capsule contains doxepin, as the hydrochloride, 10 mg. (NDC 0018-0356), 25 mg. (NDC 0018-0357), and 50 mg. (NDC 0018-0358) capsules in bottles of 100 and 1000.

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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

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YEAR 2000/*Continued*

Advancement brings problems

By John J. Coury, Jr., MD Port Huron

It is indeed an interesting challenge to predict the type of medical practice we will have in the year 2000.

When one reminisces over 25 years of an active surgical practice, it is amazing to note the fantastic progress that has taken place in medicine. It is a joy to see the disappearance of many mortal diseases because of scientific and clinical progress. Improvement in the quality of life for the average US citizen continues to accelerate at a faster pace than for any other country in the world. I sincerely believe this has been made possible only because of the individualism and independence of our scientists, our practitioners and our patients.

Yet, as joyful as all this may seem, there are equally distressing signs that we will not maintain our acceleration and progress at the same rate because of roadblocks set up by a local minority of liberal intellectuals and social engineers.

Woe to us if we accept the laissez-faire attitude of the British and some Western European countries toward the scientific and socio-economic aspects of our medical system. Karl Marx said, "He who controls the health of the people, controls the nation."

Warning about apathy

But I am optimistic enough to believe that our multi-ethnic society will not permit a nationwide, complacent attitude to medical care and bring about a socialization and degradation of our delivery system. However, I must warn you that it is going to take the intense and undivided effort of every medical professional as well as his/her patients if we are to progress and improve upon our delivery of medical care and continue to improve the quality of life of our patients. And I do predict that we will have a nationwide health system — but one controlled and advised by the medical professionals who are delivering that care.

Scientific advances

Procedural changes in medicine have occurred because of the improvement of scientific and clinical investigations. This continuing change in the practice of medicine during my 25 years as a surgeon continues to amaze me. "No way" do we practice medicine in surgery as we did 10 years ago, 20 years ago and 30 years ago. The profession as a whole can be proud of this. As a surgeon I predict that in 25 years we no longer will be doing mutilating surgery for neoplastic diseases. These entities will be primarily controlled and contained by immunotherapy as well as other chemotherapeutic agents. However, I believe surgery still will be the mainstay for congenital deformities, trauma, acute disease, appendicitis, perforated ulcers, hernia repair, hemorrhage, obstructions such as gallstones, kidney stones, adhesions and bezoars. There still will be a place for the surgeon.

I predict the field of radiology as we know it will be entirely changed, with invasive techniques essentially eliminated and the use of computerized axial tomography in the great majority of diagnostic studies. Radiotherapy by the year 2000 will be much more sophisticated and much less needed for malignant diseases with the advent of immunotherapy.

Contagious diseases as we know them today almost will be a thing of the past. However, in the year 2000 I feel that we will be deeply involved in attempting to treat the secondary and tertiary phases of venereal diseases, primarily syphilis. I state this because of the great increase of venereal disease country-wide today. I need not go into the causes such as increased promiscuity and the lack of moral and religious responsibilities.

Doctor Coury

We shall continue to have amazing discoveries in the field of cardiovascular surgery. I am convinced by the year 2000 we will have a replaceable mechanical heart or a transplant therapy in cardiovascular and other forms of surgery with no host rejection. Major advances in cardiovascular and transplant surgery will not only improve the quality of life but markedly lengthen the survival rate.

Medical philosophy

A physician will continue to be "the captain of the ship" and he will become increasingly more efficient because of scientific advances. We have seen this increase in efficiency over the past 30 years as a physician has been able to give constructive care rather than sit at the bedside holding the patient's hand, waiting for the "crisis to occur."

If we are to keep our nation on a course leading to continued scientific advancements and improvements of the public's health and medical care, it is mandatory that there be a cooperative effort by all providers of health and medical care in a unified front. Our willingness to accept this role as a public servant will depend in a large measure on whether wise decisions in health matters are made in communities, the state and this nation.

Doctor Coury is MSMS past president and serves now on the AMA Board of Trustees.

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Michigan physicians accepting CME, study shows

Doctor Rush

By William E. Rush, MD Palm Springs, CA

Michigan physicians will accept mandatory Continuing Medical Education without a great deal of objection and will be participating actively in CME programs.

That is one of the primary results of a survey of the 35 organizations which had been accredited as of this writing by MSMS to provide Category 1 programs for Michigan physicians.

The survey was sent to the doctor who has CME programming responsibility for each of the accredited organizations. Thirty-two of 35 responded. See **Table 1** for views about the "general reaction of medical staffs."

The sponsors reported that they would offer more CME **(Table 2). Table** 3 reviews the replies given when asked what increased use they plan to make of educational aids. Mentioned most often were use of the topic-preference questionnaires, and guest faculty.

Table 4 showed that 19 of 32 felt that mandatory CME would increase the use of the medical audit in determining CME topics.

All but two of the respondents reported that mandatory CME had increased attendance. See **Table 5.**

Table 6 describes the projected benefits from the new Michigan mandatory CME law. Of the replies, 30 said attendance would increase, 19 believed that CME programs would be improved, and 12 felt that new programs would be developed. Eight of the respondents felt that CME budgets would be increased.

Ensuring competency

Now let me trace some of the history of the mandatory CME movement and include some of my personal views.

For the past three to four years there has been almost constant debate in many halls on a few issues; the geographic and specialty maldistribution of physicians, the foreign medical graduate, the annual number of medical school graduates (currently it is feared there will be too many) and more recently, the popular topic has become professional competency. Turning to tools of their domain, government officials have hit upon re-licensure requirements as a means to demonstrate their concern.

Consumers, too, are becoming increasingly involved in matters affecting their lives, not simply for their input but for their education as well. It has been accepted that health care is a right. Current statements of that right now call for accessability, availability and more recently, competency. Living as we do in an era of public accountability and change, the medical profession itself is changing. Witness changes in the status of various groups in medicine; women, racial minorities and homosexuals. Health care facilities are developing the currently popular, "sense of corporate responsibility."

In the past, physicians were islands of themselves, accountable only to themselves. In the very early days of medical audit, "I am not responsible for the activities of other physicians" was heard in all of our hospital corridors. Through peer review programs physicians have indeed become their brothers' keepers.

The government would have us believe that utilization review and medical audit programs are a result of their requirements, but the concept of peer review and medical audit as one means of quality appraisal came from our own ranks. People such as Virgil Slee, MD, of MAP-PAS and Clem Brown, MD, were advancing the concept of audit and education more than ten years ago at the University of Colorado Medical Staff Workshops in Estes Park and at meetings of the Association for Hospital Medical Education. Recently, with government prodding, worthwhile refinements and increased activity in utilization review and audit programs have been seen. These, too, have added to health care costs.

Physicians have traditionally believed in "staying abreast" and it is most likely that the majority of our practicing physicians do attempt in

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Doctor Rush is medical education director, Desert Hospital, Palm Springs. Until November he was associate dean for curriculum affairs, associate professor of pediatrics and acting director, Division of CME, WSU School of Medicine.

various ways to maintain their competency through continuing education.

Determining audience need

In addition to quality appraisal programs in health care institutions, medical organizations have instituted a variety of programs to assure competency. In keeping with the tradition of self-designed education programs, 22 medical specialty (or physician specialty) groups offer self-assessment examinations to their members, and 13 specialty boards either have implemented recertification programs or have set specific dates for implementation. The methods to be utilized will include participation in approved continuing medical education programs, self-assessment programs, written examinations, individual practice profiles and other new procedures.

Fourteen state medical societies have established mandatory continuing medical education for membership and in 16 states, legislation has been passed which authorizes licensure boards to require participation in continuing medical education as a requisite for re-licensure.

In Michigan we all are familiar with the huge problem of accrediting sufficient institutions to provide the newly-required 50 hours of continuing medical education for physicians. The MSMS CME Commission, composed of 20 physician members, in its first year accredited 35 organizations for CME.

The commission continues to meet each month to review and accredit new applicants.

As it seems to me, steps now must be taken to determine what the audience needs to learn. If CME programs comply with these new laws in the simplest manner, their planners will be shirking their responsibilities and the public may have been sold a bill of goods. Means of determining educational needs by measuring audience competence through group and/or individual practice profiles must be developed and programs designed to meet those identified needs.

Actually, with mandatory CME, the audience will be there. Existing methods must be modified and new means of measuring competency must be developed as a means to reach our common goal — optimal health care for our nation.

TABLE 1

General Reaction of Medical Staffs

Vehement objection	5
Little objection	17
No objection	8
Favorable reaction	2

TABLE 2

Change in Hours of CME Offered

No change	7
Increase:	
1 - 10%	3
10 - 25%	13
25 - 50%	5
75 - 100%	3
Decrease	1

TABLE 3

Increased Use of Educational Aids

Self Instruction Programs	4
Guest Faculty	8
Pre-Program Tests	2
Post-Program Tests	4
Topic Preference Questionnaires	10
Audience Participation Projects	3
Visual Aids:	
35 mm Slides	5
Transparencies	4
Motion Pictures	5
TV Tape	4
Other Teaching Aids	2

TABLE 4

Change in Role of Medical Audit

Increased use of audit in determining topics	19
No change:	
Good relationship as before	3
Still little relationship	10

TABLE 5

Attendance Change

No change	2
Decrease	0
Increase:	
25%	14
25 - 50%	13
50 - 75%	2
75 - 100%	1

TABLE 6

Effects of New Law

Beneficial:	
Develop new programs	12
Improve programs	19
Increase attendance	30
Increase budget:	
Allocations	8
Tuition	3
Hindrance in any way	2

Michigan leads in screening Medicaid-eligible children

By Richard Currier, MA
Lansing

It is good for your health to be poor in Michigan.

That is, if you are under 21 years of age and poor, the best place to be so is in Michigan. This State is a nationally recognized leader in implementing a comprehensive health care program mandated by Congress in 1967 for children and youth eligible for Medicaid benefits.

Through this program — Early and Periodic Screening, Diagnosis and Treatment (EPSDT) — state administrators of health care programs are required to seek out the recipient and arrange services as needed. Initiative must be taken not only in explaining, inviting, baby sitting and transporting clients as needed to a health screening site, but also in insuring that services needed for health problems are obtained. States refusing to comply with this law are to be penalized through a reduction of federal funds for Aid to Dependent Children.

EPSDT in Michigan

The new law was received with considerable apprehension. Although EPSDT was an Act of Congress in 1967, it was six years later before the first client was screened in Michigan.

Perhaps "revolutionary" is too strong a word to characterize this law. Without question EPSDT is innovative. The methodical recruiting, screening, diagnosing, and treating of a huge number of children had never been tried in this country. Neither workers nor training courses were available to "sell" preventive health care to people who are often more occupied with the next meal or the next rent payment rather than possible future poor health. Little help could be expected from current health care systems which are interventive, not preventive, in nature.

Designing a battery of brief, low cost health tests for screening thousands of children is a small task compared to the training of a large number of nurses, technicians and clerks to implement a screening program. How would health providers in the traditional professions react to this sudden invasion of hundreds of new workers in the health field doing unfamiliar and untried things?

Initially, the burden of the new program fell primarily on nurses. It was their responsibility to coordinate a screening clinic, convince local administrators of the value of this program (which fortunately is funded totally from state and federal resources), and to encourage health professionals to accept referrals made as a result of the health screening. Careful planning and clear guidelines provided by state administrators and consultants eased the burden of county workers considerably. Within six months from the date of beginning, health screening became available to the 500,000 eligible children and youths in Michigan.

Four years and 436,000 screenings later a new perspective is developing.

In the beginning years the State Department of Public Health gave much attention to hiring, training, and monitoring health screening staff to insure a high level of reliability in the tests administered. It believed that performance of high quality would encourage greater confidence among doctors in the validity of the program and greater conviction among the clients regarding the need of preventive health care.

Quality alone in the screening portion of the EPSDT, however, is not enough. Through experience of the past four years it is becoming increasingly evident that the key to success of this program is in the skill of the outreach coordinator. Someone must continue to foster awareness of the need for preventive health care among the Medicaid population and at the same time involve the screening staff effectively in the health needs of Medicaid clients.

Convincing individuals of the value of preventive practice to preserve their health is no easy task. Preventive medicine is like a battle that never happened, it never makes news. It is clear that outreach work constitutes by far the major portion of the total EPSDT program.

The Michigan Department of Social Services (MDSS) subcontracted the screening portion of EPSDT to the Michigan Department of Public Health. It was a wise first step but represented only a beginning.

Outreach now emphasized

The MDSS must now deal with the much more complex portion of the program that it reserved for itself, namely, outreach work. The early success of the Michigan EPSDT program cannot continue unless increasing attention is directed toward community involvement.

In addition, the finest health care system in the world is useless unless a bridge is constructed joining the real situation in which users are found with the professionals in the health field. Adding to the complexity of the problem is that in the health industry itself all is not harmony. Conflict of roles often arises

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Mr. Currier is EPSDT coordinator, Michigan Department of Public Health, Bureau of Personal Health Services.

Mr. Currier

between providers such as clinical nurses versus physicians, counselors versus educators, public health nurses versus outreach workers.

Yet, because need far exceeds health care resources, a mediating and coordinating skill is in great demand for preserving and enhancing the health of the community.

Workers need to be aware not only of conditions in which many people live but also the variety of resources available to meet needs. There are many public and private agencies that can be called upon to alleviate a situation. If the worker is skillful enough to deal with immediate felt needs, rapport will be established that will open the ear of the client to a preventive health care program.

The ongoing success of EPSDT will depend in large measure on lasting personal involvement of client and worker joined in the mutual concerns of providing the best of health care for the client's children. Outreach workers must, however, as Rollo May points out, lead the clients to be responsible for their own health and that of their children and must discourage a passive role of dependency on a doctor.* If the client believes his or her life has important purpose, care for health becomes an important means for achieving a goal.

Administrators and staff of the Michigan EPSDT program have had remarkable success compared to the programs in most other states. By no means, however, has the EPSDT venture reached perfection.

Preventive health care is the way to treat the more difficult health problems in our complex modern society. Michigan's EPSDT clearly shows that mass preventive programs for children are possible and opens the door for new advances in the preventive health care field.

**Confrontation with Death,* Rollo May, Preventive Medicine, Vol. 5, #4, 1976, pp. 508, 517.

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Commentary

By Arthur A. Ulmer, MD Detroit

(The following is excerpted from Doctor Ulmer's inauguration speech delivered January 31.)

Our system with its continuing maturation has the potential of providing the finest medical care of any scheme in the world today. Like all systems of care it has some problems, but unlike many, it has inherent in its democratic structure the mechanisms for correcting its deficiencies without massive dictatorial government intervention. It is our job to utilize these mechanisms toward that end.

This is the context wherein the need for an organization such as the Wayne County Medical Society becomes evident and important for both the patient and the physician. The medical "society" structure based on county, state and national organizations is at present the medical providers' only "unified" voice.

Medical society best guide

It is principally the society structure, with its many volunteers giving countless hours of service, that can help guide Medicine's future in the best interests of the public and physicians.

I see no new major problems in the coming year that we are not already concerned with. Some may reach a major decision state in the near future, however. The prospect of a major decision by the Congress on National Health Insurance, of course, is the most imminent.

Current opinion polls suggest Americans favor some change in health care, but how broadly Congress acts may well determine whether or not we take an irretrievable step toward a total welfare state.

It is organized medicine's responsibility to provide leadership, not only to its members, but to the nation at this time. No longer can there be opposition without presenting viable alternatives, and no longer can decisions be based on desire or expediency.

Must face reality

We must support our leadership in assembling the hard facts, interpreting them rationally and moving toward solutions dictated by those facts. We need not compromise principle but do need to face reality squarely.

The task is not easy but with strong support for its leadership, a rational solution to America's health crisis is possible.

The medical profession should not have to warn that no man or group is an "island" and any philosophy imposed on medicine will soon spread to all groups and individuals in our society. We need only to look to the malpractice crisis to exemplify this. Originally it was "Medicine's problem" and the unconscionable demands and costs engendered on the physician were largely ignored by the public since they were not immediately directly affected.

However, the cancer has quickly spread to other professions and groups, including the manufacturing industry, where a product liability crisis is rapidly developing which affects every individual in the nation. Now we hear a public cry beginning to develop for relief. I predict that all the other regulation enacted or proposed for the medical profession will soon find its counterpart in all facets of our society. Let us hope those crying for a restructuring of medical practice will take heed of the possible consequences.

The first priority of our County Society is to those problems close to home on which we can have maximum impact.

In order to meet its continuing responsibilities in an effective manner as possible the WCMS will look intently at some proposals for organizational change within itself to improve membership communication and broader membership participation in the Society decision-making processes.

A concerted attempt to increase membership personal services will be made. In the early months of this year the Society will conduct a membership survey on possible areas of expanded services. Beyond those areas already mentioned, we will consider services related to office management, CME reporting, professional liability, and legal and business assistance.

Medicine today is constantly receiving criticism for many problems which are outside of its realm of control. Social problems are not identified as such but are purported to be medical system deficiencies.

We must always be aware, however, that Medicine is a unique profession, calling for responsibilities and decisions unlike those found in any other profession. Our strength and public impact lies in being first and foremost physicians, compassionately concerned with our patients' welfare.

Integrity doctor's strength

We are the world's best physicians but often the world's worst politicians. Put to rest promptly any idea that in any way we can surpass our antagonists in their skillful dialogue and well-financed political power. However, we cannot allow Medicine to go unimpeded down a road that will surely destroy its greatness. There is a time to stand athwart history and cry "halt!"

I have faith the public will heed the cry and espouse our cause, but only as long as they can respect our integrity as physicians. Keep the altruism and idealism that characterizes the doctor on entering the profession.

We can best combat our adversaries by nurturing and reasserting the strengths that lie within us as quality physicians.

Doctor Ulmer is new president of the Wayne County Medical Society.

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*nonobstructed; due to susceptible organisms

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Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase o urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes othe than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

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* **Indications:** When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

Contraindications: Further use in progressive renal or hepatic dysfunction; hyperkalemia. Preexisting elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs. Routine use of diuretics in otherwise healthy pregnancy.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K^+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy.** Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium® (triamterene, SK&F Co.), and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

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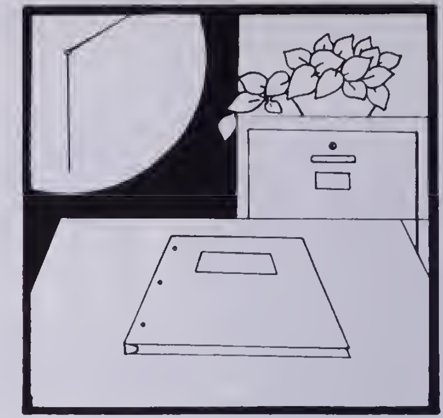

Some basic tips to prudent investing

By David M. Buegeleisen
Southfield

The "Employee Retirement Income Security Act", enacted in 1974, governs the funding, benefits, and investments of employee retirement trusts. Although the primary purpose of the Act was to protect employees who had seen retirement benefits disappear, its provisions cover all corporate retirement plans.

One of the principal features of the act is the provision that all investments of any trust must meet the Prudent Man Rule. This rule defines a prudent investment as one which a prudent man might make with his own money.

Another feature of the Act is to provide that trustees are liable for the performance of the trust to the extent that they have failed to follow the Prudent Man Rule. In a professional corporation with more than one employee, the Prudent Man Rule must be closely observed since there is the possibility of lawsuits by discontented former employees and their heirs.

The purpose of this article is to discuss the alternative types of investments which are generally considered to meet the Prudent Man Rule.

Philosophy

Since these trusts do not pay any taxes, it is vital to understand the effects of compounding income. If assets are invested to bring a return of 8% and all income is reinvested at 8%, the original investment will double in nine years. The higher the income, the faster the trust will grow. The object is to find investments which will do so.

As this is a tax-free trust, it is vital to take as few risks as possible as any losses disrupt the compounding process. In a taxable account losses can be charged off against ordinary income and thus are reduced by the tax saving. They may also be carried forward to offset future gains. This is not the case in a tax-free account and the trustees must guard against any losses which interfere with the long-term building process.

The investments which are generally considered satisfactory Prudent Man investments are discussed below:

Fixed Income Securities

Any security which promises to pay a specific amount of interest or income every year and the principal upon stated maturity, is called a fixed income security. Money market instruments are fixed income securities which are issued for short periods (usually two years or less) and include short term obligations of the U.S. Treasury (called T-Bills), certificates of deposit issued by banks, and commercial paper issued by large corporations such as General Motors or Sears. Savings accounts are also considered money market instruments. The name "money market instruments" is used because these instruments are in reality very close to money.

The benefits of these instruments are the lack of fluctuation in resale value, and the ease with which they can be converted into cash. Their principal drawback as long-term investments is their lower rate of return than longer term bonds. They are generally used as a parking lot for temporarily idle funds so as to provide income while these funds are between more permanent investments.

Longer term "promises to pay" are called bonds. There are two types of bonds which are used in pension and profit-sharing trusts: corporate and U.S. government. Bonds paying interest which is tax-exempt, are not used as they generally pay less than U.S. or corporate bonds because of the appeal of their tax-free feature. All U.S. government bonds are of equal quality and all U.S. government agency bonds are considered substantially as good as the direct obligations of the U.S. Government. However, corporate bonds range in quality from investment grade to outright gambles. Generally the higher the rate of return, the lower the quality and vice versa.

The basic appeals are the stability of income and priority of payment of principal and income. Thus, a company to stay in business must pay its bondholders their due. If it does fail, the bondholders have priority over most creditors and all stockholders. All U.S. government bonds and many corporate bonds are very easily bought and sold. This assurance of income underwrites the stability of bond prices as compared with stocks. The risks involved with bonds in addition to the problems of the issuer are their market price fluctuations which occur with changes in interest rates. During times of falling interest rates, bonds may provide some capital appreciation.

Mr. Buegeleisen is an investment counselor.

Mortgages are a third form of fixed income security. They generally provide a somewhat higher rate of return than other fixed income securities because they lack marketability and because their debt is secured by a piece of real estate or equipment — the value of which may radically change over the term of mortgage. Because of these drawbacks they are not often found in portfolios or trusts with assets of less than $5 million.

Equities

Equity is the ownership of assets. The most common forms are common stock and ownership of real estate. Since dividends can and often do change with the growth and contraction of corporate earnings, there is no fixed rate of return.

The primary reasons for a trust buying stock is for capital appreciation and liquidity. Stock in a well-run growing company offers the holder the possibility of increased future income in the form of dividends. Stocks which do not pay dividends are usually not considered suitable prudent man stocks. Some very high-dividend-paying stocks of high quality are sometimes used in place of bonds if there is any anticipation of dividends increases. But generally stocks are purchased because of the capital appreciation.

The risks in stocks are the obvious ones of market fluctuations and changes relating to the changes in the underlying company's position, vis-a-vis, its competition and a host of other economic factors. Quality, volatility, dividends, and marketability must be considered before common stock selections are made.

Preferred stocks are equities with a fixed dividend which does not change. They most closely resemble fixed income securities and are used in the same manner as bonds are in a trust.

Convertible Securities

These are securities which provide a fixed rate of income but which under stated conditions can be converted into common stock. Thus, they will rise with the common stock prices but there will be a floor under them due to the fixed income feature. Also, they generally fall between the bonds and common stock as to their priority of principal payment. As a rule, they are of lower quality than most bonds and are usually issued by a company which is unable to sell the equivalent amount of common stock. Care must be exercised in the use of these securities in trusts, as many convertible securities are not of sufficient quality to be included in Trust Portfolios.

Real Estate

Since vacant land is not income-producing, only income producing real estate meets the Prudent Man Rule. Capital appreciation and income are the main attractions in real estate investments. Poor marketability is probably the principal drawback to real estate ownership in trusts. Since most real estate is priced to include the benefits of the tax-saving feature of depreciation, many real estate investments are better suited to taxable accounts than to tax-free trusts. Where real estate is used as an investment vehicle, it should be kept to a small percentage of the assets because of its lack of liquidity.

Insurance

Many smaller trusts find the ownership of ordinary life insurance provides the beneficiaries of the trust with considerable tax advantages. Participation in ordinary life policies is recommended as the cash values build equity thus aiding the compounding effects. Term insurance does not help build the value of the trust.

The Prudent Man Rule dictates that the assets of any trust must be diversified so as to provide against unforeseeable events which may occur, and to reduce risk. As a rule of thumb, no more than 10% of the assets should ever be in one investment other than highest quality money market instruments, or U.S. government obligations. Also, to the extent possible, marketability should be considered so that the trust may respond quickly to changing conditions.

Colloquium in Maternal-Fetal Medicine

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With income tax time approaching, Michigan physicians are reminded that their contributions to the AMA's Educational and Research Fund are tax-deductible, as long as a specific Michigan college or university is designated as recipient of the donation.

Donations to the AMA-ERF, a special continuing project of the MSMS Auxiliary, are distributed to medical students to help pay their way through school.

In 1976, a total of $24,926.07 was donated by Michigan physicians to the AMA-ERF, with $13,493.25 of it going to students at U-M Medical School, $6,829.34 to students at WSU School of Medicine, and $4,603.48 to MSU College of Human Medicine students.

WELCOME/*Continued*

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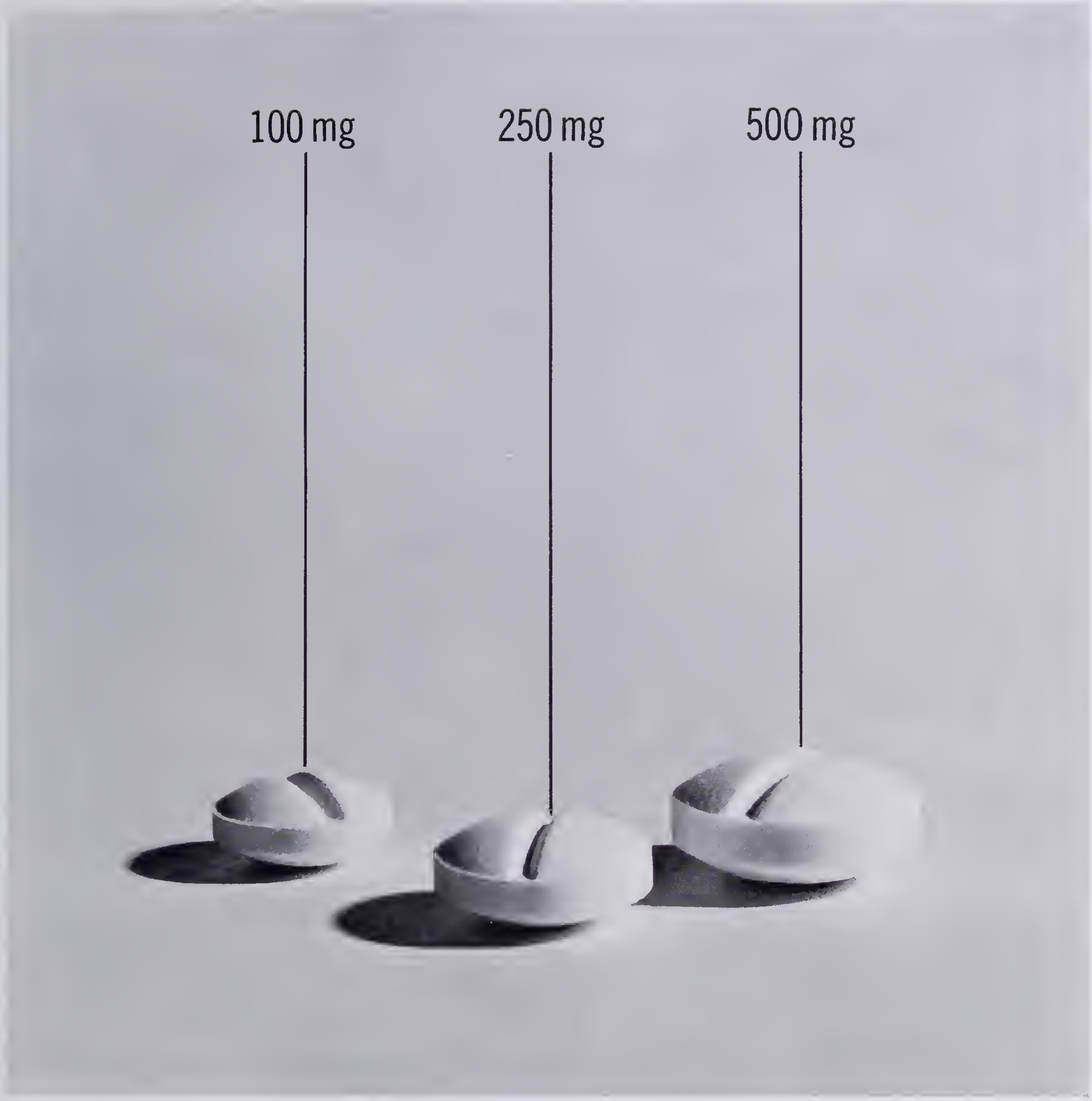
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for vertigo*

▪ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

▪ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

▪ **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed
professional information
available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Category I Courses

Michigan Medicine *each month will carry a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of the new Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing will indicate a contact person, so the physician can obtain details. The list will be expanded as courses are developed by accredited sponsors. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.*

Date: March 15, Cancer of the Colon and Rectum. Location: Wayne County Medical Society headquarters, 1010 Antietam, Detroit, 48207. **Sponsor:** WSU Department of Oncology. **For:** All interested physicians. **Cost:** $20. **Contact:** WSU Division of CME***. **Approved for:** 2½ hours of Category I Credit.

Date: March 16, Lecture Series in Ophthalmology, "The Treatment of Lid Elevation." Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Ophthalmologists. **Cost:** No charge. **Contact:** Department of CME, Sinai Hospital of Detroit****. **Approved for:** 2 hours of Category I Credit.

Date: March 20 - June 8, Clinical Nuclear Medicine II. Location: Scott Hall, Wayne State University. **Sponsor:** WSU Department of Radiology. **For:** Radiologists. **Cost:** $66. **Contact:** WSU Division of CME**. **Approved for:** 20 hours of Category I Credit, 2 hours per session.

Date: March 23, Infant Nutrition: A Foundation for Lasting Health. Location: Veteran's Memorial Building, 151 West Jefferson Avenue, Detroit. **Sponsor:** The University of Iowa College of Medicine, and the National Heart, Lung and Blood Institute. **Co-sponsor:** The National Kidney Foundation, The Committee on Atherosclerosis and Hypertension in Childhood, and the Council on Cardiovascular Disease in the Young of the American Heart Association. **For:** All interested physicians, via a closed circuit symposium. **Cost:** None. **Contact:** Pat Coleine, Health Learning Systems Inc., ℅ Health Projects International, Inc., 200 Madison Avenue, New York, 10016. **Approved for:** 34 hours of Category I Credit, (The TV symposium: 3 hours, Pre & Post Tests: 14 hours, Supplementary study: 8 hours, Visiting Faculty: 9 hrs)

Date: March 23, Heart Day. Location: Saint John Hospital, Detroit. **Sponsor:** Saint John Hospital. **For:** Cardiologists. **Cost:** $50. **Contact:** Linda Radu, Dept. of Medical Education, St. John Hospital, 22101 Moross Road. **Approved for:** 7 hours of Category I Credit.

Date: March 23, Carcinoma of the Uterus. Location: Grace Central Hospital. **Sponsor:** WSU School of Medicine. **For:** All interested physicians. **Cost:** $20. **Contact:** WSU Department of CME**. **Approved for:** 2½ hours of Category I Credit.

Date: March 23-24 — Winter-Spring Perinatal Conference and Northeastern Wisconsin Perinatal Program. Location: Terrace Motor Inn, Escanaba. **Sponsor:** Northeastern Wisconsin Perinatal Intensive Care Unit, St. Francis Hospital, Escanaba, and MSU UP Medical Education Program. **For:** All interested physicians. **Cost:** $20. **Contact:** William LeMire, III, MD, Doctors Park, Escanaba 49829. **Approved for:** 8 hours of Category I Credit.

Date: March 23 - June 7, Physics of Nuclear Medicine and Diagnostic Radiology. Location: Scott Hall, Wayne State University. **Sponsor:** WSU Department of Radiology. **For:** Radiologists. **Cost:** $66. **Contact:** WSU Division of CME**. **Approved for:** 20 hours of Category I Credit, 2 hours per session.

Date: March 24-25, Hematology Review: Morphology and Laboratory Techniques. Location: Towsley Center, U of M Medical Center. **Sponsor:** Simpson Memorial Institute, U of M Departments of Internal Medicine and PGM/HPE. **For:** Clinicians and laboratory personnel. **Cost:** $80. **Contact:** U of M Office of Intramural Education*. **Approved for:** 12½ hours of Category I Credit.

Date: March 26-27, AMA Regional Program. Location: Michigan Inn, Southfield. **Sponsor:** AMA and MSMS. **For:** All interested physicians. **Cost:** $140. **Contact:** AMA Council on Scientific Assembly, 535 N. Dearborn, Chicago 60610. **Approved for:** 12 hours of Category I Credit.

Date: March 27-29, Cardiology Update. Location: Indianhead Ski Lodge, Wakefield. **Sponsor:** Michigan Heart Association. **For:** All interested physicians. **Cost:** $100. **Contact:** Mrs. Eleanor D. Peterson, Michigan Heart Association, P.O. Box LV 160, Southfield, 48076, (313)557-9500. **Approved for:** 10 hours of Category I Credit.

Date: March, A Course on Clinical Depression, Part III—"Clinical Depression: Current Concepts of Diagnosis." Televised: WEYI-TV, CBET, WUHQ-TV. **Sponsor:** University of Pennsylvania. **Co-sponsor:** Pfizer Laboratories Division. **For:** Primary care physicians. **Cost:** $5. **Contact:** Ms. Anne Hearn (215-662-2849), or your local Pfizer Representative. **Approved for:** Up to 9 hours of Category I Credit.

Date: March 30 — Symposium on Congenital Heart Diseases in Infants, Children and Adults. Location: Haufman House Mid-Way Motor Lodge, Grand Rapids. **Sponsor:** Michigan Heart Association. **For:** All interested physicians. **Cost:** $30. **Contact:** Michigan Heart Association, 16310 W. Twelve Mile, PO Box LV-160, Southfield 48076. **Approved for:** 5 hours of Category I Credit.

Date: March 30-31 — Annual Michigan Conference on Maternal and Perinatal Health. Location: Kalamazoo Center Inn, Kalamazoo. **Sponsor:** MSMS. **For:** All interested physicians. **Contact:** Herbert Auer, MSMS headquarters. **Approved for:** Tentative 7 hours of Category I Credit.

Date: April 2, Workshop on Children with Cardiac Problems. Location: Oakland University, Rochester. **Sponsor:** Michigan Heart Association. **For:** MDs, DOs, parents, students, allied health professionals, nurses, social workers, VNA. **Cost:** Physicians—$20. **Contact:** Shelley Rader, Michigan Heart Association, P.O. Box LV 160, Southfield, 48076. **Approved for:** 5 hours Category I Credit.

Date: April 4 - June 18, Medical Cytogenetics. Location: Scott Hall, WSU School of Medicine. **Sponsor:** WSU Department of Pathology. **For:** Pathologists. **Cost:** $100. **Contact:** WSU Division of CME**. **Approved for:** 20 hours of Category I Credit, 2 hours per session.

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*Office of Intramural Education, University of Michigan Medical Center, Dep't. of PGM/HPE, Ann Arbor, 48109

**WSU Division of CME, Room 1209, Scott Hall, 540 E. Canfield, Detroit, 48201 (313) 577-1453

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902

****Department of CME, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 272-6000

Date: April 5-6, Obstetrics and Gynecology Conference. Location: Towsley Center, U of M Medical Center, Ann Arbor. **Sponsor:** U of M Office of Intramural Education. **For:** Obstetricians/Gynecologists. **Cost:** $100. **Contact:** U of M Office of Intramural Education*. **Approved for:** 11½ hours of Category I Credit.

Date: April 6, Dermatology for the Generalist and Internist. Location: Zuckerman Auditorium, Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Dermatologists, internists and generalists. **Cost:** To be determined. **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 3 hours of Category I Credit.

Date: April 14, 1977 Michigan Conference on Medical Aspects of Organized Athletics. Location: Towsley Center, University of Michigan Medical Center, Ann Arbor. **Sponsor:** MSMS CME Programming Committee. **For:** All interested physicians. **Contact:** Herbert Auer, MSMS headquarters. **Approved for:** 5 hours of Category I Credit.

Date: April 18-22, Family Practice Review. Location: Towsley Center, U-M Medical Center, Ann Arbor. **Sponsor:** U of M Office of Intramural Education. **Co-Sponsor:** Mich. Academy of Family Physicians. **For:** Family Physicians. **Cost:** $250. **Contact:** U of M Office of Intramural Education*. **Approved for:** 37½ hours of Category I Credit.

Date: April 19-21, Physiology of the Ovary. Location: Scott Hall, WSU School of Medicine. **Sponsor:** WSU Department of Gynecology and Obstetrics. **For:** Obstetricians/Gynecologists, Family physicians. **Cost:** $100. **Contact:** WSU Division of CME**. **Approved for:** 20 hours of Category I Credit.

Date: April 20, Lecture Series in Ophthalmology, "The Pediatric Patient with Nystagmus." Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Ophthalmologists. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 12 hours of Category I Credit.

Date: April 21-23, Critical Care Symposium, "Monitoring of the Critically Ill." Location: Wayne County Medical Society, 1010 Antietem Road. Detroit. **Sponsor:** WSU School of Medicine. **For:** All interested physicians. **Cost:** $95 physicians in practice; $45 physicians in training. **Contact:** WSU Division of CME**. **Approved for:** 12 hours of Category I Credit.

Date: April 26-28, Electrocardiograph Diagnosis. Location: Towsley Center, U of M Medical Center, Ann Arbor. **Sponsor:** U of M Medical School DPM/HPE, Office of Intramural Education. **For:** Family physicians, internists. **Cost:** $180. **Contact:** U of M Office of Intramural Education*. **Approved for:** 20 hours of Category I Credit.

Date: April 29-30, 10th Annual Cancer Symposium. Location: Scott Hall, WSU School of Medicine. **Sponsor:** WSU Department of Oncology. **For:** All interested physicians. **Cost:** $75. **Contact:** WSU Division of CME**. **Approved for:** 14 hours of Category I Credit.

Date: May 4, Recent Advances in Pediatric Surgery. Location: Children's Hospital of Detroit. **Sponsor:** WSU Department of Pediatrics. **For:** Pediatricians, family physicians, surgeons. **Cost:** $35. **Contact:** WSU Division of CME**. **Approved for:** 6¼ hours of Category I Credit.

Date: May 5-6, "Annual Clinic Days," Recent Advances in Pediatrics. Location: Children's Hospital of Detroit. **Sponsor:** WSU Department of Pediatrics. **For:** Pediatricians. **Cost:** $75. **Contact:** WSU Division of CME**. **Approved for:** 12 hours of Category I Credit.

Date: May 5-6, Ophthalmology Conference: Cornea and External Disease. Location: Towsley Center, University of Michigan Medical Center. **Sponsor:** U of M Medical School PGM/HPE. **For:** Ophthalmologists. **Cost:** $140. **Contact:** U of M Office of Intramural Education*. **Approved for:** 14 hours of Category I Credit.

The following have been accredited by MSMS Commission on Continuing Medical Education:

Organizations:

Ann Arbor Psychiatric Association
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Society of Anesthesiologists
University of Michigan School of Public Health

Hospitals:

Alma-Gratiot Community Hospitals, Alma
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med.Center, PC/Little Traverse Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Detroit-Macomb Hospital Association
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Henry Ford Hospital, Detroit
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital), Muskegon
Marquette General Hospital
McLaren General Hospital, Flint
Mercy Hospital, Port Huron
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Oakland Medical Center, Pontiac
Oakwood Hospital, Dearborn
Pontiac General Hospital, Pontiac
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Edward Sparrow Hospital, Lansing
Traverse City State Hospital, Traverse City
V. A. Hospital, Battle Creek
Wayne County Psychiatric Hospital, Eloise
West Shore Hospital, Manistee
Ypsilanti State Hospital, Ypsilanti

Date: May 11, Common Clinical Problems in Pulmonary Disease. Location: Kalamazoo Hilton Inn. **Sponsor:** Southwestern Michigan Area Health Education Center. **For:** Any interested physicians. **Cost:** $10. **Contact:** Charles Zeller, SMAHEC, (616) 383-6398. **Approved for:** 7 hours of Category I credit.

Date: May 12, Common Dermatologic Problems. Location: Towsley Center, U of M Medical Center. **Sponsor:** U of M Office of Intramural Education. **Co-sponsor:** Michigan Academy of Family Physicians. **For:** Family physicians. **Cost:** $60. **Contact:** U of M Office of Intramural Education*. **Approved for:** 6 hours of Category I Credit.

Date: May 12-13 — Annual Heart Days. Location: Hyatt Regency Dearborn. **Sponsored by:** Michigan Heart Association. **For:** All interested physicians. **Cost:** $40. **Contact:** Michigan Heart Association, 16310 W. Twelve Mile, PO Box LV-160, Southfield 48076. **Approved for:** 12 hours of Category I credit.

Date: May 16-20, Advances in Internal Medicine. Location: Towsley Center, U of M Medical Center. **Sponsor:** U of M Office of Intramural Education. **For:** Internists. **Cost:** $225. **Contact:** U of M Office of Intramural Education*. **Approved for:** 35 hours of Category I Credit.

Date: May 17, Cancer of the Cervix. Location: Wayne County Medical Society, 1010 Antietam, Detroit. **Sponsor:** WSU Department of Oncology. **Co-sponsor:** Detroit Cancer Club. **For:** All interested physicians. **Cost:** $20. **Contact:** Dorothy Bewley, Dept. of Oncology, Wayne State University, 4160 John R., Detroit 48201. **Approved for:** 2½ hours of Category I Credit.

Date: May 18, Pediatric Dermatology Seminar. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** Pediatricians, family practitioners, dermatologists. **Cost:** $50. **Contact:** Office of CME, St. John Hospital, Detroit, (313) 881-8200, ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: May 25, Multiple Myeloma. Location: Grace Central Hospital. **Sponsor:** WSU School of Medicine. **For:** All interested physicians. **Cost:** $20. **Contact:** Dorothy Bewley, Department of Oncology, Wayne State University, 4160 John R., Detroit 48201. **Approved for:** 2½ hours of Category I Credit.

Date: May 26, Pathology Conference. Location: Towsley Center, U of M Medical Center. **Sponsor:** U of M Office of Intramural Education. **For:** Pathologists. **Cost:** To be determined. **Contact:** U of M Office of Intramural Education**. **Approved for:** 6 hours of Category I Credit.

Date: June 2-3, Blood Banking. Location: Towsley Center, U-M Medical Center. **Sponsor:** Office of Continuing Education, Dept. of PGM/HPE. **Co-sponsor:** American Society for Medical Technology. **Cost:** $75. **Contact:** Office of Continuing Education, Dept. of PGM/HPE, U. of M.**. **Approved for:** 13 hours of Category I credit.

Date: June 7, Continuing Pathology Conference. Location: Towsley Center, U-M Medical Center. **Sponsor:** Office of Continuing Education, Dept. of PGM/HPE. **Cost:** $20. **Contact:** Office of Continuing Education, Dept. of PGM/HPE, U. of Michigan**. **Approved for:** 6 hours of Category I credit.

Date: June 8-10, Pulmonary Disease Workshop. Location: Towsley Center, U-M Medical Center. **Sponsor:** Office of Continuing Education, Dept. of PGM/HPE. **Co-sponsor:** M.A.F.P. **Cost:** $180. **Contact:** Office of Continuing Education, Dept. of PGM/HPE, U. of M.**. **Approved for:** 22 hours of Category I credit.

Date: June 10 - 12, Workshop on Human Sexuality for Physicians and Health Care Professionals. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital Department of Psychiatry. **For:** Physicians, Psychologists, Social Workers and other Health Care Professionals. **COST:** $175. **Contact:** Norman Rosenzweig, MD, (313)272-6000, Ext. 8516. **Approved for:** 22 Hours of Category I Credit.

Date: June 15-24, Advanced Institute in Methods of Immunological Diagnosis. Location: Cranbrook Educational Community, Bloomfield Hills. **Sponsor:** Wayne State University School of Medicine. **For:** All interested physicians. **Cost:** $600. **Contact:** Noel R. Rose, MD, PhD, Department of Immunology and Microbiology, WSU, 540 East Canfield, Detroit 48201. **Approved for:** 60 hours of Category I credit.

Date: June 20-24, Northern Michigan Summer Conference. Location: Shanty Creek Lodge, Bellaire. **Sponsor:** Office of Continuing Education, Dept. of PGM/HPE. **Cost:** $200. **Contact:** Office of Continuing Education, Dept. of PGM/HPE, U. of M.**. **Approved for:** 22 hours of Category I credit.

Date: June 22, Carcinoma of the Thyroid. Location: Grace Central Hospital, Detroit. **Sponsor:** WSU School of Medicine, Dept. of Oncology. **For:** All interested physicians. **Cost:** $20. **Contact:** Dorothy Bewley, (313-494-6025), 4160 John R, Detroit, Mi 48201. **Approved for:** 2½ hours of Category I Credit.

Date: Monthly, Ob/Gyn Journal Club. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** All interested physicians. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital*. **Approved for:** 2 hours of Category I Credit.

Date: Saturdays, Morbidity and Mortality Conference. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital Department of Surgery. **For:** Surgeons. **Cost:** None. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 2 hours of Category I Credit per session.

Date: Monthly, Cleft Palate Clinic. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Oral Surgeons, plastic surgeons, pediatricians. **Cost:** None. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 3 hours of Category I Credit.

Date: Monthly, Tissue Audit (Cancer). Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Surgeons, ob-gyns, pathology, radiology. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 2 hours per session Category I Credit.

Date: Second Thursday of each month, Inter-Hospital Pathology Slide Conference. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** Pathologists. **Cost:** No charge. **Contact:** Department of CME, St. John Hospital, 22101 Moross Road, Detroit, 48236, (313) 881-8200. **Approved for:** 3 hrs. each date Category I Credit.

Date: Every Tuesday morning, Gynecology/Obstetrics Combined Grand Rounds. Location: Jackson Auditorium, Hutzel Hospital. **Sponsor:** Wayne State University Department of Gynecology-Obstetrics. **For:** All interested physicians. **Cost:** No charge. **Contact:** Wayne State University, Division of CME**. **Approved for:** 4 hours each of Category I Credit.

Date: Every Saturday, Weekly Conference. Location: Gamble Building, Burns Clinic/Little Traverse Hospital, Petoskey. **Sponsor:** Burns Clinic/Little Traverse Hospital. **For:** All interested physicians. **Cost:** None. **Contact:** Ernest W. Carpenter, MD, 560 West Mitchell, Petoskey, 49770.

Date: Begins September, 1976, Continuing Training in Family Therapy. Location: Suite 1212, North Park Plaza, 17117 W. Nine Mile Road, Southfield. **Sponsor:** Family Institute of Southeastern Michigan. **Co-sponsor:** Ackerman Institute. **For:** Psychotherapists. **Cost:** Varies according to time put in. **Contact:** Carolyn R. Tourkow, MSW, director, Family Institute of Southeastern Michigan. **Approved for:** Hours vary with time spent.

Date: Each Wednesday, Detroit Medical Center Hand Conference. Location: Classroom 3, Second Floor, Webber Wing, Harper Hospital, Detroit. **Sponsor:** Wayne State University. **For:** Surgeons. **Cost:** No charge. **Contact:** Joseph L. Posch, MD, Fourteenth Floor, Kales Building, 76 W. Adams, Detroit 48226. **Approved for:** Hour-for-hour Category I credit.

THE NEW MSMS GROUP PLANS **DO** WORK

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Jon H. Blum, M.D.
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"My responsibilities include placing insurance for several physicians, a medical laboratory, and our medical center building. New Hampshire Insurance Company and the Stratton people have consistently provided superior coverage at the lowest cost."

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Heartbeat

By Mert Scholten
MSMS Communications Department

Donald C. Camp, MD, Niles, is new president of the Michigan Society of General Surgeons. A fellow in the American College of Surgeons and a diplomate of the American Board of General Surgery, Doctor Camp has practiced in Niles since 1958.

Michael Clark, MD, Lansing, MSU resident serving at Ingham Medical Center and Sparrow Hospital, is new president of the Emergency Medicine Residents Association. He is a clinical instructor and visiting lecturer at MSU's medical school and at Lansing Community College.

James Davis, MD, South Haven, is now director of public health for Cass, St. Joseph, Branch, Hillsdale and Van Buren counties. Doctor Davis succeeds Douglas Mack, MD, now director of the Kent County Health Department.

Thomas J. DeKornfeld, MD, Ann Arbor, U-M professor of anesthesiology, is new chairman of the AMA Joint Review Committee for Respiratory Therapy Education. DeKornfeld, director of the U-M Medical Center Office of Allied Health Education, will serve a two-year term as head of the committee, national accrediting agency for more than 400 schools of respiratory therapy in the U.S.

William Eyler, MD, Detroit, chairman, Henry Ford Hospital Department of Diagnostic Radiology, was recently awarded the Gold Medal of the Radiological Society of North America. The annual oration at this meeting was given in honor of the late **Howard Doub, MD,** founder, Ford Radiology Department who was also a recipient of the Gold Medal.

Albert Farley, MD, Saginaw, is new president of the Michigan Society of Neurological Surgeons. He succeeds S. M. Farhat, MD, of Ann Arbor for a two-year term of office.

Allan Giddings, MD, Augusta, was featured in a special article in the *Kalamazoo Gazette* recently. The 93-year-young Augusta native was interviewed while spending an afternoon at a local library taping his memoirs as part of a Bicentennial project. The article is filled with anecdotal material from the doctor's life, both as a boy and as a physician. Doctor Giddings is justifiably pleased that "In 63 years of practice I never had to turn down a house call because of illness."

Thomas Hall, MD, Traverse City, is new chairman of the Munson Medical Center Board of Trustees. Hall, a Traverse City native, has been practicing urology since 1967 and has been a member of the Munson Board of Trustees since 1973. His father, James Hall, MD, practiced medicine in Traverse City from 1945 to 1971.

Edward A. Krull, MD, Detroit, is new chairman of the Department of Dermatology at Henry Ford Hospital succeeding **Clarence S. Livingood, MD,** who remains on the staff as a department member. Doctor Krull trained in the Ford dermatology department and established a private practice in Grand Rapids prior to returning to Ford Hospital. He is the current president of the Michigan Dermatology Society. Doctor Livingood began at Ford Hospital in 1953 and organized the dermatology residency program, one of the largest in the country.

Raymond S. Lord III, MD, Kalamazoo, is new director, Midwest Oncology Center, Borgess Hospital. He succeeds **William G. Tucker, MD, Kalamazoo,** director of the Center since its formation in 1969. Doctor Tucker will devote more time to oncology research.

Fazlolah Nickhah, MD, Ypsilanti, recently received a special Certificate of Appreciation from the Midwest Chapter of the American College of Sports Medicine. "Dr. Nick," as he is known, was a founder and the first president of the MACSM. A former Olympic performer, Nickhah has been an Olympic team physician and long dedicated to the ideals and philosophies of sports medicine. He served four terms as president of MACSM.

Winston B. Prothro, MD, Grand Rapids, retired director of the Kent County Health Department after 22 years, is now full-time associate director of the Michigan Office of Local Health Service of the Michigan Department of Public Health. He serves as liaison between the state and 47 local health departments.

Herbert A. Raskin, MD, Birmingham psychiatrist, has been appointed by Governor Milliken to be a member of the Michigan Advisory Commission on Substance Abuse Services.

John A. Rupke, MD, Grand Rapids, is new vice-speaker of the Council of the American College of Emergency Physicians.

Sheikh Saeed, MD, Detroit, division head of hematology and the Ford Hospital blood bank, has been elected to a three-year term on the board of directors of the Michigan Chapter of the American Red Cross.

Bernard M. Schuman, MD, Detroit, will assume the presidency of the 1,500-member American Society for Gastrointestinal Endoscopy in May at the group's annual meeting. Prior to being named president-elect last year, Doctor Schuman had served as the Society's secretary as well as chairing the membership committee.

Alfred B. Swanson, MD, Grand Rapids orthopedic surgeon specializing in reconstruction of the hand, was guest lecturer at several medical meetings and seminars in recent months in London, Edinburgh, Lund, Paris, Utrecht, Acapulco, Mexico City, and New York. He was featured in an article in the November 8, 1976 issue of *People* Magazine and in the December 26, 1976 magazine section of *The Detroit Free Press*.

Eugene C. Timmerman, MD, Coopersville family physician for 41 years, was honored in January as the 1976 "Man of the Year" by the Coopersville Rotary Club. Doctor Timmerman built and staffed the Coopersville General Hospital.

V. K. Vaitkevicius, MD, Detroit, Professor and Chairman of WSU School of Medicine, Department of Oncology, is president of the American Association for Cancer Education for 1977.

MICHIGAN AUTHORS . . . **Richard C. Bates, MD, Lansing,** a member of the MSMS Committee on Drug and Substance Abuse, had another article published in *Medical Economics* Jan. 10, 1977. Entitled "I've Stopped Covering for 'Sick' Doctors," the article calls for all physicians to join in the effort to rehabilitate colleagues who may be somehow impaired in their practice effectiveness through alcoholism or drug abuse. . . **Jeoffrey K. Stross, MD, D. Michael Shasby, MD, and William R. Harland, MD, Ann Arbor.** "An Epidemic of Mysterious Cardiopulmonary Arrests" published in the Nov. 11, 1976 issue of *The New England Journal of Medicine* . . . **Edwin O. Pearson, MD, and Hector R. Mena, MD, Kalamazoo,** "Multiple Epiphyseal Dysplasia," Dec. 6, 1976 issue, the *Journal of the American Medical Association* . . . **D. H. Drachler, MD, J. G. Weg, MD, both of Ann Arbor and George H. Koepke, MD,** formerly of Ann Arbor and now of Saginaw, "Phrenic Nerve Injury from Subclavian Vein Catheterization," *JAMA*, Dec. 20, 1976.

Medicine/Osteopathy

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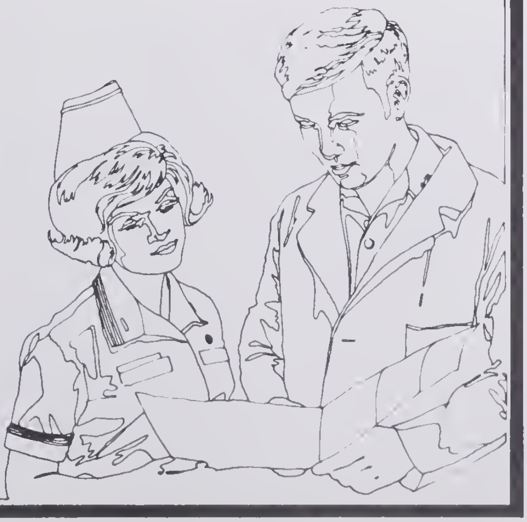

MDPH Rationale for Advising Mothers About PBB Levels and Breast Feeding

Two studies were conducted by the Michigan Department of Public Health during the fall of 1976, to provide estimates of the percentage of nursing mothers whose breast milk tested above specific parts per million of PBB in milk fat. One study involved a random sample of 59 women who delivered in one of 147 lower peninsula hospitals during August 15 through August 21, 1976 and the second study involved a random sample of 49 women who delivered in an upper peninsula hospital during the month of August 1976. Samples were collected by local health departments and tested in the laboratories of the Bureau of Disease Control and Laboratory Services, Michigan Department of Public Health. The present analysis represents about 92% of the selected women.

The PBB levels in the breast milk fat samples from the lower peninsula women ranged from non-detectable to 1.22 ppm with a median value of 0.068 ppm. In the samples from upper peninsula women, the range was from non-detectable to 0.320 ppm with over half the samples showing PBB not detectable. The following table shows these figures.

PBB Range in Breast Milk Fat in ppm	# of Women in Study Lower Peninsula Study	Upper Peninsula Study
Total	53	42
Non-detectable	2	24
Detectable up to 0.05[3]	16	15
0.05 up to 0.1	17	2
0.1 up to 0.5	15	1
0.5 up to 1.0	2	—
1.0 and above	1	—

It is not appropriate to use the tolerance guideline level of 0.3 ppm set by the FDA for meat and milk when considering advice to mothers concerning breast feeding. The FDA is required to establish an actionable level as part of its statutory responsibilities. This level is based on consideration of the total amount of the chemical that might be received as a result of long term, regular ingestion of foodstuffs and represents the legal limits for sale of foods, not the limits of toxicity. Sufficient safeguards must be built in so that consumers purchasing foods can do so without fear of adverse effects from the chemicals therein. Thus, levels below the guidelines are considered safe, but levels above the guidelines cannot necessarily be considered unsafe. Safety margins of at least 10 to 100 times below the lowest level thought to produce any adverse effects are built into tolerance guidelines.

The Department of Public Health has concluded arrangements with the Environmental Research Group, Inc., P.O. Box 322, 313 North First Street, Ann Arbor, MI 48107 to provide those nursing women who desire it an analysis of the PBB in their breast milk. The cost of this analysis ($25) is to be paid out of third party pay resources available to the patient, including Medicaid, or, for those not having such resources, by the state health department. Samples for testing should be submitted to Environmental Research Group, Inc., directly and it is necessary that their sample collection kit be exclusively used for submitting breast milk samples for testing. These kits, including all necessary instructions, are available directly from ERG or through your County Health Department.

It has not been possible to establish quantitative limits that separate safe from unsafe concentrations of PBB in breast milk. It is most likely that the PBB concentration in the newborn approximates that of the mother. If the infant is breast fed by the mother, it will receive additional PBB but, since the infant's fat tissue increases rapidly during the first six months, the concentration of PBB in the tissues will not be significantly higher at the end of this time than at birth. After weaning, the infant's body concentration will fall as it grows because he will receive little, if any, additional PBB through his food supply. Thus, the infant's exposure is for only a limited period.

Consideration of the levels of PBB in breast milk in the general population of Michigan women has led a panel of experts advising the Michigan Department of Public Health to recommend that these women not be advised to terminate breast feeding because of PBB exposure.

On the other hand, the Department in the past recommended to women with high exposures and breast milk levels on the order of 20 to 90 ppm of PBB not to breast feed, and the panel concurred in continuing this recommendation. It is not known that this higher level would cause any toxicity, but it seems prudent to discourage such high exposures.

Thus the guidelines suggested in counselling a concerned woman are whether she had any intense exposure to PBB or whether her breast milk level is within or close to the range observed in the general population or is considerably higher.

The following table summarizes the estimated levels in women in the lower peninsula of Michigan and is intended to assist you in comparing your patient's level to that in other women. In using the table, for example, if your patient has a level of PBB in the fat of her breast milk in parts per million of 0.10, then approximately 65% of the lower peninsula women have levels less than her level and 35% have levels greater than her level.

If a woman has level of PBB in fat of breast milk (ppm)	then the approximate % of lower peninsula women —	
	having levels less than hers is:	having levels greater than hers is:
0.05 ppm	30%	70%
0.07 ppm	50%	50%
0.10 ppm	65%	35%
0.30 ppm	87%	13%
0.50 ppm	94%	6%
1.00 ppm	98%	2%

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143 Cortland Avenue, Rockford, 49341, Telephone (616) 866-9395

Meetings

(see also Category I listing on page 154)

April 14-17 — Annual Meeting, State of Michigan Branch, American Association of Medical Assistants, Kalamazoo Civic Center, Kalamazoo, contact: Mrs. Ginger Hyatt, Chairman, 2533 Cumberland St., Kalamazoo 49007.

April 20 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, Director.

April 19-21 — International Symposium on "Human Ovulation" at C. S. Mott Center for Human Growth and Development, Wayne State University School of Medicine, Detroit, contact: Dr. E. S. E. Hafez, C. S. Mott Center.

May 2-4 — 51st Annual Convention, MSMS Auxiliary, Troy Hilton, Troy, contact: Mrs. Francis P. Rhoades, 272 Ashland Avenue, Detroit 48215.

May 6 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director.

May 7 — Seventh Annual Workshop, Michigan Speech Pathologists in Clinical Practice, Holiday Inn, 26555 Telegraph, Southfield, contact: Mrs. Toton (313) 353-0310.

May 13-15 — 1977 Annual Session, MSMS House of Delegates, Troy Hilton, Troy, contact: Richard Campau, MSMS Headquarters.

May 14 — May Seminar, "Lymphoreticular Disorders," sponsored by the Michigan Society of Pathologists at Hurley Hospital, Flint, contact: Jacob E. Briski, MD, Saint John Hospital, 22101 Moross Road, Detroit 48236.

May 16-27 — Health and Chronic Disease among the Elderly, Ann Arbor, contact: Dorothy H. Coons, Director of Cont. Ed., The Institute of Gerontology, The University of Michigan-Wayne State University, 520 East Liberty, Ann Arbor, Michigan 48109.

May 24-27 — Annual Meeting, Michigan Public Health Association, Park Place Motor Inn, Traverse City, Michigan, contact: MPHA 484-3044 or James K. Edmunds, (313) 577-1400.

May 25-28 — Annual Conference, Association for the Care of Children in Hospitals, Hyatt Regency Hotel, Dearborn, contact: Mary Frances Podolak, RN, Childrens Hospital of Michigan, 3901 Beaubien Blvd., Detroit 48201.

May 26-27 — Annual Gull Lake Conference, sponsored by MSMS Maternal and Perinatal Health Com-

MSGS

Michigan Society of General Surgeons

PURPOSE

To give General Surgeons a socio-economic organization designed to aid them in their dealings with governmental and other third parties.

FUNCTIONS

To protect the public interest.
To protect the surgeon from intervention in performance of his professional duties.
To gather information regarding General Surgery, to inform ourselves and to provide a solid factual basis for dealings with others.
To join with similar organizations of other specialties to promote our common aims.
To make available to interested people or organizations, opinions and recommendations which could be helpful to planners of present or future programs where they relate to surgery.
To strive toward standardization and simplification of the paper work involved in the practice of surgery.

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For further information write Glenn E. Moore, MD, 1915 Lincoln Dr., Flint, Mich. 48503, Secretary-Treasurer.

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mittee, MSU Conference Center, Gull Lake near Kalamazoo, contact: Helen Schulte, MSMS headquarters.

June 13-17 — Seminar, Speech, Language and Hearing Problems of Older Persons: Identification and Management, Arts and Architecture Building, U of M, Ann Arbor, contact: Dorothy H. Coons, Director of Cont. Ed., The Institute of Gerontology, The University of Michigan-Wayne State University, 520 East Liberty, Ann Arbor, Michigan 48109.

June 15 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director.

June 18-22 — AMA Annual Convention, San Francisco.

July 11-22 — Seminar, Biology of Aging, Arts and Architecture Building, U of M, Ann Arbor, contact: Dorothy H. Coons, Director of Cont. Ed., The Institute of Gerontology, The University of Michigan-Wayne State University, 520 East Liberty, Ann Arbor, Michigan 48109.

July 22-24 — MSMS Council, Deer Lake, Boyne Falls, Michigan, contact: Warren Tryloff, MSMS Director.

August 6-10 — Annual Convention and Scientific Assembly of the Michigan Academy of Family Physicians, Sugar Loaf Mountain, contact: Charles Schoff, MD, 5209 Sunset Drive, Midland, Michigan 48640.

September 7 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director.

November 2 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director

December 14 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director

Placard describes psychiatrists' role, training

"The training and functions of a psychiatrist" are spelled out on a new 8 × 11 placard produced recently by the Michigan Psychiatric Society. The card is designed for display in physicians' offices to educate patients and the rest of the public.

The cards, which include five basic steps in the training of a psychiatrist, are available by contacting the MPS at 120 W. Saginaw St., East Lansing, 48823.

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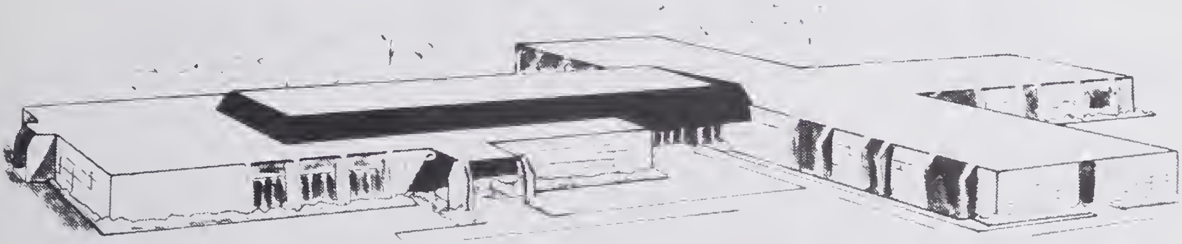

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In Memoriam

Anthony D. Calomeni, MD
Lansing

Anthony D. Calomeni, MD, Lansing, died Jan. 28 at the age of 72. An ophthalmologist for 30 years, Doctor Calomeni was affiliated with E. W. Sparrow and St. Lawrence hospitals of Lansing. He was graduated from Wayne State University School of Medicine and was a member of the Detroit Ophthalmology Society and the American Geriatrics Society.

Clayton S. Emery, MD
St. Joseph

Clayton S. Emery, MD, a general practitioner and obstetrician, died Jan. 24 at the age of 83. A graduate of University of Michigan Medical School, Doctor Emery was affiliated with St. Joseph Memorial Hospital.

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Charles D. Fess, MD

Charles D. Fess, MD, Jackson, died Jan. 16 at the age of 59.

A graduate of University of Michigan Medical School, Doctor Fess was past president of Hancock Medical Society. He also served in the U.S. Army during WWII.

Herbert G. Fowler, MD
Portland, Ore.

Former Michigan psychiatrist Herbert G. Fowler, MD, 57, died Jan. 30. Doctor Fowler was to be awarded the Lenin Prize in May by the Soviet Union for his outstanding accomplishments in Michigan with unique and effective methods of administering a large state hospital. He was affiliated with the Whitecloud Center at the University of Oregon Health Sciences Center at the time of his death.

Doctor Fowler, who was graduated from the University of Michigan Medical School, belonged to the American Psychiatry Association, the Indian Task Force of the Academy of Child Psychiatry, the Committee on Indian Affairs for the American Psychiatry Association and was the Oregon representative of the minority section of the American Association of Medical Colleges. He had been an assistant professor of psychiatry at the University of Utah and, from 1970-74, an associate professor of psychiatry at Michigan State University as well as a consultant at the Battle Creek, Michigan Veterans Administration Hospital, acting superintendent of Kalamazoo State Hospital and a psychiatric consultant at Allegan County Community Mental Health Center. Doctor Fowler also headed the psychology department at Allegan General Hospital.

J. Stewart Hudson, MD
Grosse Pointe

J. Stewart Hudson, MD, internist, died Jan. 22 at the age of 87. Doctor Hudson was graduated from the University of Western Ontario in Canada. He was an assistant medical superintendent at Harper Hospital before going into private practice. During WWI, Doctor Hudson served as a major in the Canadian Army Medical Corps and with the First Canadian Mounted Rifles.

Richard T. Scherock, MD
Mt. Pleasant

Richard T. Scherock, MD, 34, died Jan. 19. A graduate of the University of Michigan Medical School, Doctor Scherock was affiliated with Radco Central's radiology department and was on the medical staff at Central Michigan Community Hospital and Gratiot Community Hospital.

Cullen E. Sugg, MD
Grand Rapids

Cullen E. Sugg, MD, Grand Rapids surgeon for 39 years, died Jan. 16 at the age of 81. Doctor Sugg, a graduate of the University of Michigan Medical School, was affiliated with St. Mary's and Butterworth hospitals of Grand Rapids. He was a life member of the American College of Surgeons.

All Michigan MD liability premiums listed here

The table at right provides the current professional liability premium rates for physicians insured under the three companies covering MDs in Michigan.

The rates reflect two increases by the Brown-McNeely Fund since its founding in 1975, and one recent increase by the Medical Protective Company.

The Michigan Physicians Mutual Liability Company has incurred no rate increases since its official accreditation in 1976, and its administrator, William Cheeseman, East Lansing, reports no rate increases currently are foreseen by the company.

Professional Liability Insurance Rates
($100,000/$300,000 Coverage)
As of January 1, 1977

AREA 1

Class	MPMLC	Brown-McNeely	Medical Protective
1	$ 1,500	$ 2,240	$1,383
2	1,800	2,240	1,383
3	3,650	4,480	2,064
4	7,600	8,960	3,887
5	9,350	11,200	6,112
6	9,850	11,200	6,112
7	11,600	13,440	9,156
8	11,850	13,440	9,156

AREA 2

Class	MPMLC	Brown-McNeely	Medical Protective
1	$ 1,100	$ 1,680	$ 872
2	1,300	1,680	872
3	3,100	3,360	1,296
4	6,900	6,720	2,567
5	7,800	8,400	3,997
6	8,500	8,400	3,997
7	9,800	10,080	5,338
8	10,900	10,080	5,338

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FOR FURTHER INFORMATION: Contact Fulvio M. Ferrari, M.D., Chief of Clinical Affairs, Northville State Hospital, Northville, Michigan 48167.

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EMERGENCY PHYSICIANS needed by established corporation in University town. Paid professional liability insurance, salary negotiable. Positions available July 1, 1977 Send C.V. to Mt. Pleasant Emergency Room Services, P.C. 2929 S. Isabella Road, Mt. Pleasant, Michigan 48858. Phone (517) 772-4767.

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PSYCHIATRIST — Suburban Detroit area hospital has a fulltime staff vacancy for a psychiatrist to assume the responsibilities of director of outpatient mental health services. Excellent salary range, hospital-paid benefit program and regular hours. Interested physicians should submit curriculum vitae in confidence to Wesley E. Kokko, director of personnel services, Wyandotte General Hospital, 2333 Biddle Ave., Wyandotte, MI 48192 (313) 284-2400, ext. 2611.

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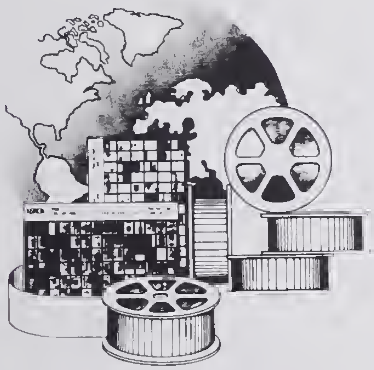

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Potpourri

By Herbert A. Auer, Executive Editor

THE PRACTICING PHYSICIAN MUST play a dominant role in whatever national health insurance arrangement is set up, declares George Eastman Pickett, MD, the new 41-year-old president of the American Public Health Association. Remember the name? Doctor Pickett, now director of the San Mateo County California Department of Public Health and Welfare, formerly was deputy director of the Wayne County Department of Health.

AMONG THE OVERWORKED WORDS these days is the word "viable." The word has had the edge ground off it, in my opinion.

GOT ANY IDEAS for good feature stories about Michigan physicians? The MSMS Communications Department would like to hear your ideas so we can relay them to Dennis Breo, feature editor in the *AM News,* or to Larry Boston, the editor.

"NEWSPAPERS SHOULD BE WARY" of writing too much about 'causes.' Causes really aren't news and often bore the readers stiff," declared Publisher John S. Knight in a recent address to the National Press Club.

A POSSIBLE 20 PERCENT DROP in patient load is seen by the Catholic Hospital Association publication, *Hospital Progress,* "if professional review board programs materialize."

"THE AMA IS TANGIBLE, it is established. It is intensely democratic. In this 20th century, the individual physician needs an organization to negotiate with government and other third parties. If the AMA is not responsive, members must remember that an organism must be stimulated if you expect it to respond." — Those are observations reported in the *Massachusetts Physician* by Mary M. Donald, MD, a new alternate delegate, after attending her first AMA House of Delegates in Philadelphia.

ONLY 14 PERCENT of the patients surveyed at the Mount Sinai Hospital Medical Center in Chicago by the Harris Organization agreed that most Americans eat the right kinds of food. And only 32 percent had any regular exercise program.

IN LANSING TODAY, the House of Representatives has 14 new members, who have an average age of 32, replacing 14 representatives whose average was 51. The average age in the House now is 45 and in the Senate, 46. In the House, the new members include four more attorneys (there are now 13); one more teacher (for a total of 17) and two more farmers (there are now 10).

WANT A SPECIFIC REASON why drug costs have increased? The *Factbook '77*, published by the Pharmaceutical Manufacturers Association explains that a major cause is that stricter government regulations require more elaborate toxicology studies.

THE CHART IS NOT THE PATIENT, contends John Gall, MD, an Ann Arbor pediatrician, in his book, *General Systemantics*. Among the other observations in the Peter-Principle-like book, are these, "Systems get in the way." "Systems take credit for what would probably have happened anyway." "Things aren't working very well — and in fact, they never did."

ANOTHER PROOF THAT COLLEGE life is changing . . . The University of Missouri reports that sales of yearbooks increased from 2,700 sales to seniors in 1975 to 4,600 sales to graduates in 1976.

Michigan Medicine Contents

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about contemporary issues and actions of the Michigan State Medical Society, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

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The Publication Committee of the MSMS Council is the editorial board of *Michigan Medicine* and advises the Council and the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

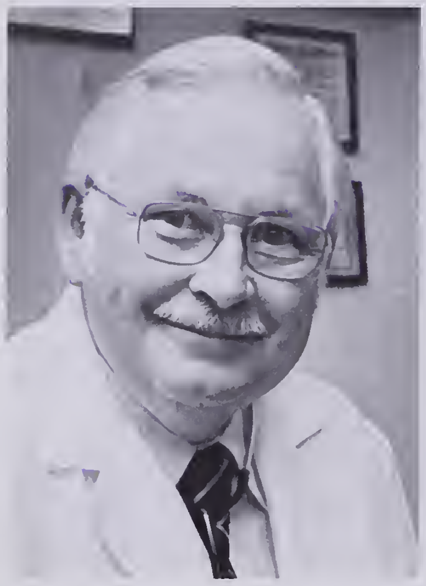
Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

In the next issue . . .

Blue Cross/Blue Shield clarifies weekend admission figures.

President's Page

"I hope to remain active and helpful..."



Robert M. Leitch, MD
MSMS President

I write this, my last President's Page article, with mixed emotions. The year has gone rapidly and for the most part pleasantly. Some exciting developments have occurred which are important to MSMS and which give me great personal satisfaction.

Among these are seeing Michigan Physicians Mutual Liability Company come to fruition and begin issuing policies for professional liability insurance. This has been a long-term dream and it appears the company is well on its way to becoming extremely important for Michigan physicians.

The new MSMS Department of Negotiations, authorized by the 1976 House of Delegates, has come into being and is beginning to show the results which its advocates expect. Surely, as we become more and more involved with government and third parties, this department will assume even greater importance.

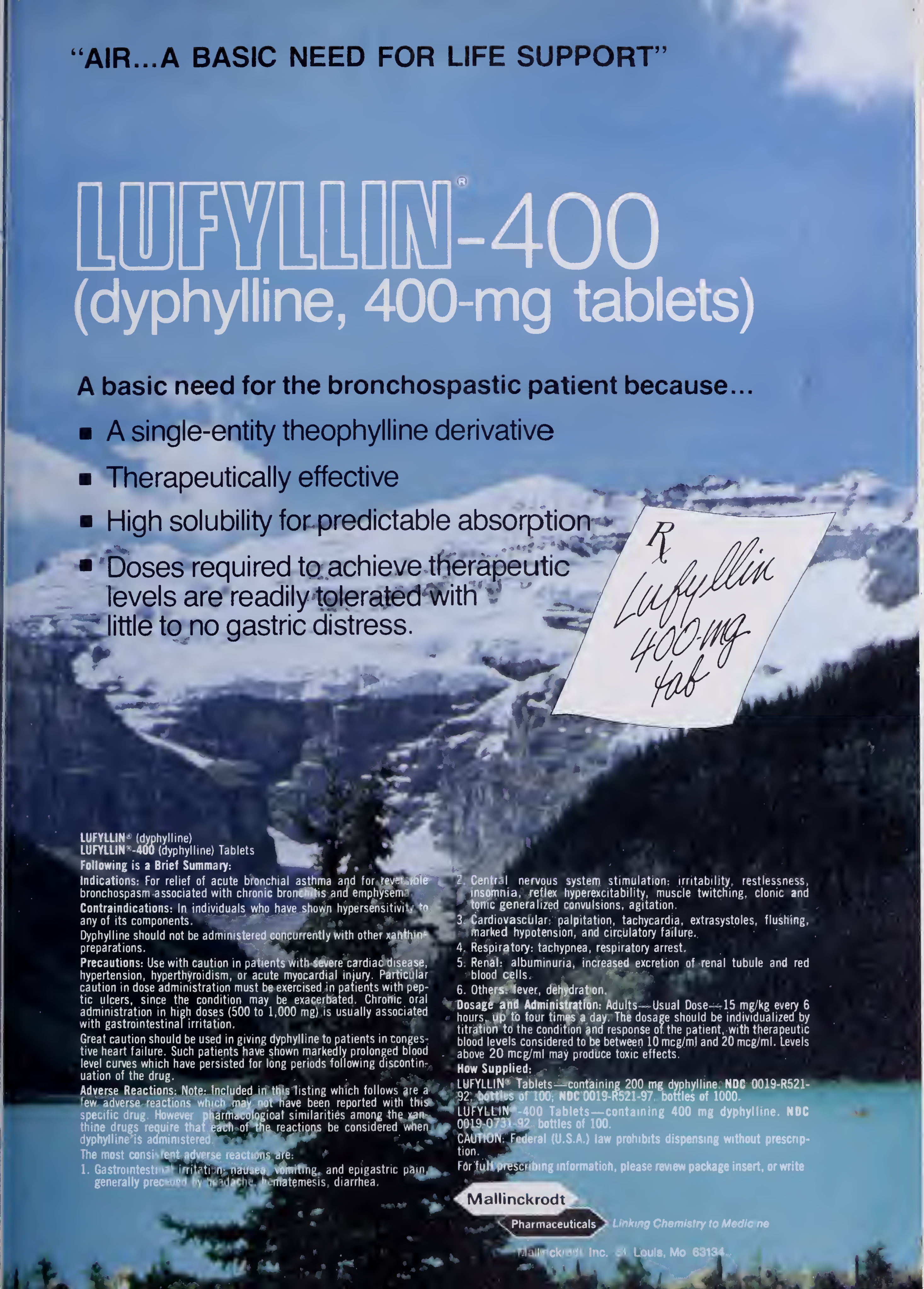
Other activities, including the initiation of arbitration as an alternative for solution of professional liability disputes, also have been undertaken. We are highly hopeful that arbitration will prove one of the important mechanisms for further easing the malpractice crisis.

The most gratifying part of my presidency has been the personal contacts with hundreds of doctors around Michigan and neighboring states. My travels have taken me from Marquette to Detroit, from Muskegon to Bay City and to many points between. I also had the privilege of attending state medical society meetings in Indiana, Ohio, and Wisconsin and found them helpful and pleasant. In addition, the give and take at AMA meetings during the last year has provided further insight into proper performance as state society president.

I wish to thank all the officers, councilors, committee members, delegates and other physicians who have contributed so much to the success of this past year. I particularly wish to thank the MSMS staff for their outstanding assistance in furthering society work and making my presidency both smooth and pleasant. We are indeed fortunate to have this highly qualified and deeply dedicated group of people.

It is not my intention to abandon organized medicine at the conclusion of my term in office. The example set by my predecessor, Brock Brush, MD, and the yeoman service he has provided during the past year as chairman of the Brown-McNeely Fund, will serve as an excellent example and guide to future activity.

I pledge my support in the future to President-elect Bass and those who follow him as president, and hope to remain active and helpful in MSMS activities in the future.



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4. Respiratory: tachypnea, respiratory arrest.
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- Advanced and basic life support
- Clinical problems in cardiac arrhythmias
- Management of common pulmonary disease
- Diagnosis and management of common neurological disorders
- Infectious disease — prevention and treatment
- Current concepts in diagnosis and treatment of diabetes mellitus
- Practical approach to the management of hypertension

The MSMS committee can offer these programs and grant Category I credits toward the recertification requirements of the Michigan Medical Practice Board and toward the requirements of the AMA Physician Recognition Award. The American Academy of Family Physicians has approved a request of the Michigan Academy so these programs carry prescribed credits.

IF INTERESTED in a possible program from 1 to 4 p.m., or from 3 to 6 p.m. before a component society meeting, or some other time frame, please write to:

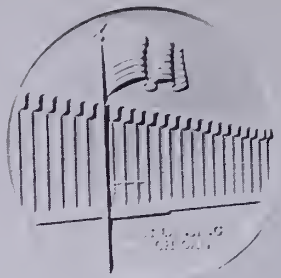
John Wiegenstein, MD, Chairman, MSMS Committee for CME Programming, 120 W. Saginaw, East Lansing, MI 48823.

Or, phone MSMS 517/337-1351 and confer with Herbert A. Auer, manager, MSMS Department for CME Programming. The committee will arrange for speakers, written materials, evaluation procedure, and record keeping. A nominal tuition charge will be made to cover the costs of the program.

MSMS insurance sells well

The following figures represent the amount of business done by the MSMS group insurance plans during 1976. The figures are provided by the MSMS insurance administrator, Stratton, Cheeseman and Associates, Inc., East Lansing.

- **Disability — 76 applications processed (45 new, 31 increases)**
- **BOE — 18 applications processed (13 new, 5 increases)**
- **Special Accident — 7 applications processed**
- **Employees Disability — 44 applications processed**
- **Group Life — 92 applications processed; Volume: $3,495,000.00**
- **Office Package/Worker's Comp. — 34 policies issued to date**



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MSMS members talk about weekend admissions

" . . . non-urgent admission *is* within our control."

By Richard Gascoigne, MD
Adrian

The strictly elective Friday and Saturday admission is an expensive and extravagant practice we can ill afford to continue.

A recent study in Michigan has once again pointed out what many have long suspected, that patients admitted electively on a Friday or Saturday probably receive only custodial or domiciliary care for 36-48 hours until the hospital gets back into its routine "five-days-a-week" schedule.

It is interesting to compare the "elective" type admission with the "non-elective" type. In the latter case, lengths of stay hold rather uniform regardless of the day of admission. But the "elective" admission entered on a Friday or a Saturday spends 1½ to 2 days more in the hospital than does the same type of case admitted on days Sunday through Thursday. The cost implications of this practice are obvious to even the most casual observer.

As practicing physicians we all are acutely aware of the spiralling costs of medical care. We should also be aware that as practicing physicians we are being held responsible for a major portion of this upward spiral. Rightly or wrongly, like it or not — that's a fact!

What can be done about it? How can you and I impact upon this problem? I am certain there are many solutions put forth by as many observers. I am equally certain there is no one solution. However, I would submit that there is something each of us can do to help decrease this wasteful outflow of health care dollars.

Very simply, it is this: We insist each take a long, hard look at the reasons for putting a patient in the hospital on a Friday or Saturday. If the patient truly needs hospital care at that time, of course the admission is justified. However, if the admission is strictly for convenience (ours or the patient's) in order to beat the Sunday rush, or to assure our patient of a surgical bed for Monday's schedule, then I think that admission is certainly open to question.

I am sure we all are trying to practice the best medicine we know how. I also feel, however, that with the responsibility of practicing good medicine comes another responsibility, namely that of trying to keep the cost of that service within reasonable bounds. There are many things that influence the cost of that service that are *not* within our control. The unnecessary, non-urgent Friday and Saturday hospital admission *is* within our control. We *can* do something about it.

Doctor Gascoigne is a general surgeon.

The question of whether hospitals should provide full services on weekends has been discussed many times, and in most states. In Illinois, a survey was taken by the state medical society and 74 per cent of the physicians said they would be willing to participate in elective surgery and routine diagnosis, etc., on weekends if the hospitals provided such services. The reply from Chicago physicians was even higher, 77 per cent.

“. . . irresponsible statements alleging irresponsible actions are to be condemned.”

By Lewis E. Simoni, MD
Flint

Lessons in history again and again demonstrate that the fall of civilizations began with the discrediting of the professional groups.

And now once again, the physician in our civilization becomes the whipping boy of the health care industry. Those who are allegedly "in the know" now charge that the admission of patients on Fridays and Saturdays is an irresponsible act. Wafting through the airways and broadly printed are catch phrases "we care," "leader of health care protection," "fighting to keep costs down," and the like. Many third party health care representatives continue to increase the volume and services in their coverage without too much concern about the actual impact on the real providers.

I am not thoroughly acquainted with recent studies on restricting weekend admissions. I would like to say and also demonstrate that this data has been with us all along. The following are extracts from a single hospital derived from Medical Audit Program (MAP) print-outs from the Commission on Professional and Hospital Activities (CPHA) in Ann Arbor.

This data by day of admission and discharge covers a 10-year period — namely, the first quarters of the years 1967, 1973, 1974, 1975, and 1976. Attention should be paid to the average stay by day of admission and the geometric mean stay by day of admission. It becomes readily apparent that the Friday and Saturday lengths of stay far surpass those of the remaining days of the week. Particularly interesting is that the percentage admitted on Fridays and Saturdays is considerably less than those of the other days of the week, and also that the percentage discharged on Fridays and Saturdays is larger.

The implications here are that those concerned with cost effectiveness in the health care system could have made this an issue for discussion many years ago when the threat of accountability was much less. The figures also demonstrate dramatically that physicians appear to behave responsibly through more weekend discharges and less weekend admissions.

There are no meaningful studies that analyze work loads by seriousness of illnesses by day of the week. One study reported in the *Journal of*

DATA BY DAY OF ADMISSION AND DISCHARGE

		All Pts.	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
FIRST QUARTER 1967	Average Stay by Day of Admission (Excluding Stay 31+)	9.3	9.0	9.1	8.9	8.5	14.0	11.2	8.2
	% Admitted On		17	18	16	16	7	8	7
	% Discharged On		8	26	17	14	15	19	9
FIRST QUARTER 1973	Average Stay by Day of Admission (Excluding Stay 31+)	7.3	6.5	7.2	7.4	6.8	9.0	7.6	6.7
	% Admitted On		18	16	14	17	12	10	13
	% Discharged On		13	13	17	15	17	17	8
FIRST QUARTER 1974	Geometric mean stay by day of admission (Excluding Stay 31+)	5.4	5.0	4.8	5.6	4.8	6.8	6.6	5.2
	% Admitted On		17	14	15	16	11	11	15
	% Discharged On		12	14	16	14	17	18	9
FIRST QUARTER 1975	Geometric mean stay by day of admission (Excluding Stay 31+)	5.4	5.1	5.2	5.5	4.6	6.6	7.0	4.9
	% Admitted On		16	14	14	17	12	11	15
	% Discharged On		12	14	16	15	18	18	9
FIRST QUARTER 1976	Geometric mean stay by day of admission (Excluding Stay 31+)	5.3	4.9	5.5	5.5	4.7	6.2	6.1	4.6
	% Admitted On		17	16	14	15	12	11	15
	% Discharged On		13	16	16	14	17	16	9

Patients staying over 30 days are counted as staying just 30 days. Use of the geometric mean avoids giving undue weight to the exceptionally long stay in a small group of patients.

In mathematical terms, the geometric mean of N numbers is the Nth root of their product, while the average of N numbers is their sum divided by N. For example, the geometric mean of stays of 2, 2, and 16 days equals $\sqrt[3]{2 \times 2 \times 16} = 4$ *while their average equals* $(2 + 2 + 16) \div 3 = 6.7$

Doctor Simoni is director of medical education at Hurley Hospital, Flint.

" . . . over-utilization can be minimized . . ."

By Thomas E. Stone, MD
Muskegon

The recent announcement in Bulletin No. 53 from the Department of Social Services, which curtails payment on elective admissions of Medicaid patients on Fridays and Saturdays, will probably have minimal effect on the admission rate at both Hackley and Mercy hospitals in Muskegon.

And if these community hospitals are representative of most hospitals in the state, we can assume that the money saved by implementing this program will be minimal. Also, in some cases the non-use of in-hospital facilities on weekends might ultimately result in even higher hospital costs.

A sampling of admissions at both hospitals in Muskegon revealed that the number of patients admitted on Friday and Saturday represented approximately 15% of the total admissions for a single week. Furthermore, several random samplings of weekend admissions indicate that less than eight percent were elective admissions and that only about seven percent of the total Friday and Saturday admissions were patients covered by the Medicaid Program.

The charts on these patients admitted on Friday and Saturday were reviewed and this revealed that almost all were classified as either emergency or urgent admissions. It was noted, however, that the length of stay for such admission was significantly longer than for those patients admitted on Sunday through Thursday. This seemed to indicate, in the cases reviewed, that the patients admitted on Friday and Saturday stayed longer because they were emergency or urgent admissions and because they were more seriously ill and/or injured and required more intensive services. The actual day of admission appears to have little to do with the length of stay. Thus, we feel that the recent Department of Social Services ruling will have little effect.

It does seem reasonable to make every hospital admission as efficient and effective as possible. However, there certainly are instances where services and facilities necessary for diagnosis and treatment in the hospital can be used and are available seven days a week. It would also seem reasonable that, in some cases, elective admissions should occur on weekends to make use of these services and in non-peak usage periods.

Most hospitals must plan staffing and supportive services for the maximum number of patients that might be admitted. When it becomes necessary to call in staff on short notice, the costs generally rise. It is usually more economical to plan staffing well in advance of need. In addition, the fixed costs in all cases continue whether or not the occupancy rate is 10% or 100%. Thus, the cost per unit of usage of the various facilities might actually, in the long run, be reduced if the usage rate was leveled.

The recent proposal by the Carter Administration to put a ceiling on hospital charges, if passed, will put further financial burdens on many hospitals already hard-pressed by rising costs. It will become ever more important to utilize available facilities and service more efficiently.

No doubt, there are some physicians who consistently admit patients to the hospital with little regard to the day of the week and with little pre-planning for the admission. All of us, on some occasion or another, are guilty of this. Competition for beds also undoubtedly exists in some hospitals.

However, I feel that with effective utilization committees, pre-admission testing and advance surgical scheduling, over-utilization can be minimized and the need for rulings such as the one contained in the recent Social Services Bulletin will be unnecessary.

Doctor Stone is a urologist.

DOCTOR SIMONI/*Continued*

Family Practice, Vol. IV, No. 1 conveys some data that the index of seriousness rises sharply on Sundays to a point where it is almost double the other days of the week. There are other studies that indicate a higher use rate of both ambulatory and inpatient care facilities by those on the welfare rolls, and there are identified a large number of constitutionally dependent patients who use the emergency room services to a high degree on weekends.

Just what is the real impact of the weekend northerly migrations on the industry?

The limiting of weekend admissions by edict makes folly of the professional review process now in place, not to mention the deleterious impact on functioning utilization reviews.

In many of our communities there are no custodial beds readily available, and those that are can be obtained at a horrendous cost. The old and the sick who are about to die, not requiring "skilled care," find all third party promises empty indeed.

What needs to be pointed out is that we operate within a complex system, and irresponsible statements alleging irresponsible actions are to be condemned.

" . . . place only those who are offending on the fire."

By Douglas F. Wacker, MD Lansing

The longer I participate in committees concerned with medical problems, the more aware I become of the truth in the molehill-mountain cliché.

Usually there are two issues that come to light: (1) A small percentage of the medical staff is at fault, and the problem is usually resolved by speaking directly to those involved. (2) There are a few individuals who enjoy troubling the waters for real or imagined problems. The solution to the latter problem is not an easy one for there will always be the dissatisfied. I believe the issue of weekend admissions resulting in the waste of medical dollars to be in the last category.

An admission and discharge summary survey was obtained from one of the larger hospitals in Ingham County. The weekly results from 1975 through September of 1976 may be considered a fair sampling of hospitals in this area. As the reader will note, this data does not bear out the newspaper account denoting a waste of medical dollars on weekend admissions for custodial care.

Observe the following daily admissions and discharges during this time period.

Day of the Week	Admission	Discharge
Monday	20%	11%
Tuesday	18%	14%
Wednesday	16%	17%
Thursday	14%	16%
Friday	9%	18%
Saturday	6%	16%
Sunday	17%	9%

These facts point out admissions for the weekend are the lowest percentage of the entire week. Observe the discharge rates of Thursday, Friday and Saturday. These discharges indicate that clearing the hospital is the goal of physicians and not admitting patients for custodial care.

Despite the findings in Ingham County, comments from apparent creditable "stirrers" require further evaluation. Where did they obtain their data? Are there hospitals and doctors condoning this? With computers located at third-party payers' offices, specific data could be obtained rather quickly which could isolate this problem if it does, in fact, exist.

With accurate information, specific cases could be made and appropriate action sought first at the local level. If this failed to correct the problem, then tough penalties should be instituted to correct this misuse of funds.

I would hasten to add that I would not do away with these "stirrers" even if it were possible because they keep us on our toes whether they are appreciated or disdained.

Professionals, regardless of their field, are becoming weary of blanket accusations. Pressure must be brought upon the "stirrers" who have a conviction to boil the pot. Do so if necessary, but place only those who are offending on the fire. Granted this takes responsibility, accuracy and intestinal fortitude on the part of the "stirrers."

However, the end result of saving some health dollars and a mutual healty respect between "stirrers" and professionals would be worthy goals.

Doctor Wacker is an otolaryngologist.

" . . . length of stay not prolonged, at our hospital, by weekend admission."

By Charles L. Oppy, MD Roscommon

The following data have been furnished to me by the record librarian of Mercy Hospital, Grayling. I feel that the discussion of weekend versus weekday admissions and resulting length of stay may well be served with figures, rather than some of the emotional responses which I have read.

I have compiled some data from our local hospital for the month of December, 1976. These data cover exactly 100 admissions which were on Friday, Saturday, and Sunday, and are as follows:

Friday	6.35 days
Saturday	6.47 days
Sunday	5.31 days

The Saturday figures are distorted somewhat by the admission of a terminal carcinoma patient whose hospital stay amounted to 60 days.

The overall average hospital stay for all diagnoses in our region is 7.4 days and the average in Mercy Hospital, Grayling, is 7.52 days.

It would seem from these figures, that the length of stay is not prolonged, at our hospital, by weekend admission. In fact, it is shorter than the average length of stay when the remaining days are considered. These figures are compiled using PAS summary.

Doctor Oppy is a family physician.

Doctor Slevin

Here are some hints for expert witnesses

By John G. Slevin, MD
Detroit

Today if anything goes amiss, the public assumes someone is at fault. Therefore, someone should be sued.

Hence, more and more MDs are being called upon to appear in court to testify. If not called as "medical experts," doctors are required only to testify as to facts. The medical expert, however is allowed to express his medical opinion, which must be based upon a reasonable degree of medical certitude.

Based upon my 33 years experience as a medical witness, I offer the following hints to other physicians who may be called to testify in court:

The first a doctor may know he is to appear in court as a witness is when he receives a subpoena. This document, issued by a Court, requires an appearance at 9 A.M. on a specific day. Must it be obeyed? Yes. Refusal means the witness can be held in contempt of court and jailed.

Rather than appear at 9 A.M. and sit all day in court, the physician should call the attorney who caused the subpoena to be issued. Ask when you will be needed to take the witness stand. Most attorneys are willing to try to call a physician at a convenient time.

Suppose you have arranged to be out of town during trial dates? The attorney can arrange to take your deposition in advance, usually at your office at a convenient time. Your testimony will be made before a court reporter, under oath. At the time of trial your testimony will be read to the jury. In non-jury trials, especially in workers compensation cases in Michigan, it is now customary to obtain medical testimony by deposition.

Appearance in Court

When a medical witness goes to court, it is important to be on time, dress conservatively, act in a professional manner.

S/he should address remarks to the jurors; use layman's language, explain in lay terms any technical terms.

The physician must be prepared to demonstrate tests and explain X-rays used. Likewise, any laboratory procedures require explanation and declaration as to whether they are normal or abnormal in this case.

Cross-Examination

The job of the opposing attorney is to try to impeach your testimony. S/he will try to do this in various ways: ask the same question in different ways seeking a discrepancy in testimony, indicate you had testified in a contradictory manner, bring to court various medical books and ask if you recognize the authors as authorities.

When medical texts are used as authorities, one possible answer is:

Counties designating 'suit-alert chairmen'

Through its component societies, MSMS is compiling a list of "suit-alert chairmen." These physicians are to monitor expert witnesses and their testimony in Michigan medical professional liability court cases.

The expert witness monitoring project has two major goals: (1) to evaluate and measure the expertise of medical witnesses, and (2) to identify the root causes of professional liability litigation so that MSMS can develop remedial in-service training programs for physicians to lessen the possibility of malpractice disputes.

Each component society is asked to designate one physician in each hospital to alert his local society about any pending professional liability litigation, especially suits going to trial, involving staff physicians.

Further information may be obtained from Richard Campau at MSMS headquarters.

Practicing MD an uniquely valuable citizen

By Rodman Jacobi, MD
East Lansing

Doctor Jacobi

So much has been spoken and written about the negative aspects of physicians' attitudes and activities as a rationalization for "socializing" medical care, that the positive elements have been almost totally overshadowed.

Even physicians themselves have been seduced into thinking that they, somehow, are the bad guys and others are the knights in shining armor. It seems to me that they should stop being so defensive and let others know about the important voluntary contributions being made to society by members of the medical profession, it is time, indeed, to blow their own horn.

As an example, it's not general knowledge that privately practicing doctors all over the United States have been and are donating impressive amounts of their practice and personal time, day in and day out, year in and year out, to teaching medical students in office as well as hospital settings. Many, in fact, are giving additional time to the education of interns and residents, also without remuneration.

The additive affect of this participation in medical education amounts to a massive display of support for the medical needs of all Americans. Name one other profession that even begins to match this demonstration of concern for its students and the ultimate quality and adequacy of numbers needed to serve the public.

Other little-advertised contributions of practicing physicians include support of secondary school and college programs, community functions and governmental agencies in their efforts to serve public needs.

In addition, the hundreds of hours spent annually attending hospital and medical society meetings to upgrade physician competence and improve patient care are a very significant element in quality assurance. All of these activities represent ways in which physicians give much of themselves with very little recognition, and without pay.

It seems clear to me, then, that members of the medical profession should not have to apologize to their detractors, who, more often than not, give nothing unless the dollar sign is attached. I say "hats off" to the American practicing physician, an uniquely valuable citizen and a living demonstration of what can be done by individuals in a free society.

Doctor Jacobi is a family physician.

DOCTOR SLEVIN/*Continued*

"Yes, they are recognized authorities in general in the field of ______. However, since the author did not examine the patient in this case and I did, therefore, I consider myself an authority in this case. No two cases are alike. So I don't agree with the author in this case."

Don't fake answers

It is common practice when examining a medical witness for attorneys to pose an hypothetical question. This involves stating all the facts in the case being tried but substituting a hypothetical person for the plaintiff. These are usually long and somewhat involved questions. If and when the Court admits the hypothetical question, the poser of the question will ask: "Based upon this question, do you have an opinion as to ______."

If the medical witness thinks he needs time to think out his answer, he can ask that the Court Reporter read back the question. This gives the witness several minutes to formulate a proper answer.

When not sure of the answer, the physician best responds with "I don't know." Better such an answer than to try to fake one. That only leads to destruction. If the question is beyond your field of expertise, preface your remarks by saying "Although that is not in my field, I do have a general opinion on it."

Another frequent question asked by the opposing attorney is "What are you being paid to testify?" The proper answer is "Nothing. I am being paid for my time to be in court and away from my practice."

Another question along similar lines is "You appear frequently in Court to testify for the defense, don't you?" If it is true admit it. Or you can say, "I do examine a number of medical-legal cases for various law firms, insurance companies and attorneys, but most of them do not come to trial."

Being a medical expert witness can be challenging. Seldom do attorneys try to brow-beat a witness as it is counter-productive.

Be objective

Keep your "cool"; an angry witness is a poor witness. Try to be responsive to questions asked. Be as objective as possible. When asked if such and such is possible, answer "It is possible but in my opinion it is not probable in this case."

Keep in mind an expert medical witness is meant to enlighten the jury on technical medical matters so the jury can resolve the issue with reasonable certainty. Thus, the medical witness is an important cog in our system of justice.

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George Christian Anthon, MD, Detroit surgeon at the time of the American Revolution.

Two hundred and two years ago this month . . .

By Alexander Blain III, MD Detroit

The USA has celebrated her 200th birthday with a full year of impressive activities. It has been exciting to recall the events that led to the founding of our nation.

But why stop with 1976, when those events are ever-important to our understanding of our country and our will to maintain freedom.

MSMS member and medical historian Alexander Blain III, MD, Detroit, is author of the following article describing the 'real story' behind the famous ride of Paul Revere, which took place this month in 1775. The brief account here should prove enjoyable and interesting to our readers.

"Listen, my children, and you shall hear
Of the midnight ride of Paul Revere,
On the eighteenth of April, in Seventy-five;
Hardly a man is now alive
Who remembers that famous day and year.

"He said to his friend, 'If the British march
By land or sea from the town tonight,
Hang a lantern aloft in the belfry arch
Of the North Church tower as a signal light, —
One, if by land, and two, if by sea;
And I on the opposite shore will be,
Ready to ride and spread the alarm
Through every Middlesex village and farm,
For the country folk to be up and to arm.' . . . "

Thus begins Longfellow's famous ballad immortalizing the heroic warning of the Minutemen two hundred and two years ago.

The truth is that because Revere was taken prisoner by the British just outside Lexington, it was a doctor who carried the alarm to Concord. This was the young physician, Samuel Prescott, MD, son of Abel Prescott, MD.

The Boston physician, Joseph Warren, MD, leader of the Committee of Safety to which Paul Revere belonged, kept watch on British troop movements in that city. These troops, under the command of General Thomas Gage, were destined to march on Concord, 20 miles to the west, to capture the arsenal there. They were believed to be eager to capture John Hancock and Samuel Adams in Lexington while on their way to Concord.

It was Doctor Warren who dispatched Paul Revere on his midnight ride along with William Dawes, another rider who also was stopped outside of Lexington. They were able to warn Hancock and Adams and allow Doctor Samuel Prescott to start his ride to Concord.

"As Longfellow has it:

"So through the night rode Paul Revere, . . .
A cry of defiance and not of fear,
A voice in the darkness, a knock at the door,
And a word that shall echo forever more! . . ."

The British regulars left Boston after one o'clock and arrived at Menotomy (now Arlington) at three o'clock in the morning of the nineteenth. There they were notified that the Minutemen were rapidly gathering at Lexington.

At dawn on the Lexington Common 60 Minutemen met the Redcoats. Many of the latter were of the "Tenth Regiment of Foot" recently stationed at the British outposts at Fort Detroit and Fort Michilimackinac and they were under the command of British Major John Pitcairn. The Major ordered the Americans to disperse. Suddenly, a shot rang out; musket fire was exchanged and then eight Americans lay dead upon the green. One Redcoat was wounded in the leg. The American Revolution had begun.

The British then resumed their march to Concord where they destroyed much of the colonists' supplies and the arsenal but soon found themselves engaged with a large and angry force of Americans.

By nine o'clock Minutemen and militia, watching smoke arising from Concord, marched over the North Bridge to engage the Redcoats and drive them out of town.

The American advance, led by a company from Acton, was met by a British barrage and then the colonists fired their first volley precipitating the British retreat to Boston. This volley — the famous "shot heard 'round the world" — was later immortalized by Ralph Waldo Emerson. His Concord Hymn was sung at the completion of the Battle Monument on April 19, 1836.

"By the rude bridge that arched the flood,
Their flag to April's breeze unfurled,
Here once the embattled farmers stood,
And fired the shot heard round the world.

"The foe long since in silence slept;
Alike the conqueror silent sleeps;
And Time the ruined bridge has swept
Down the dark stream which seaward creeps.

"On this green bank, by this soft stream,
We set today a votive stone;
That memory may their deed redeem,
When, like our sires, our sons are gone.

"Spirit, that made those heroes dare
To die, and leave their children free,
Bid Time and Nature gently spare
The shaft we raise to them and thee."

Michigan unconcerned

Meanwhile, back in Michigan the American Revolution seemed a long way away. Disease and Indian affairs were of more immediate concern to Detroit, Michilimackinac and other settlements.

The leading Detroit physician of the time was George Christian Anthon, MD, born and educated in Germany and physician to the "Companys of His Majesty's Tenth Regiment Quartered at this Post" (1774) and also to the Indians of the vicinity.

We are all pretty familiar with the American side of the story of the beginning of the Revolution. Recently David A. Amour has given a good account from the viewpoint of the British soldiers.

He writes of their retreat from Concord to Boston: "All day, a galling musket fire peppered the line of British regulars as they trudged back to Boston. Fortunately for them, the Americans lurking behind stone fences and trees proved poor shots — despite all those stories we all read as youngsters about their great marksmanship. Had they better aim, the British troops soon would have been decimated. As it was, however, American musket balls did thin the stoical line of retreating Redcoats.

"The soldiers of the British Tenth were all professionals. Dressed in bright red coats with bright yellow facings, they made easy targets. Those colors were designed, however, to make friend recognizable from foe in the thick of smoke-choked battlegrounds where the enemy might be only a few yards away. British soldiers, armed with their ponderous 14-pound "Brown Bess" flintlocks, fired a ball nearly three-fourths of an inch in diameter — the size of a large marble. Though these weapons were muzzle loaders, the soldiers were trained to fire two to three times each minute, and that made them formidable opponents. Harsh and steady discipline turned the British regular into a virtual military robot, able to withstand an enemy's fire without flinching while continuing to load and fire almost mechanically. When lines closed for hand-to-hand combat, a 14-inch bayonet was fixed to the end of the muzzle. Cold steel ended many of the 18th Century's bloody battles. All this the British Redcoat did for eight pence a day, less deductions for food and clothing.

"Slogging back toward Boston, harassed by gunfire, unable to stop for rest, the men of the Tenth must have recalled many visions of their lovely Lincolnshire in northwest England from which so many had come. Many must have wondered, too, whether they would ever see that peaceful land again. As events continued to unfold in the Colonies, very few of them ever would return to their homes. For the men of the Tenth, in fact, the timing of that first shot at Lexington couldn't have been worse. When they left their posts on the upper Great Lakes during the summer of 1774, they thought they were on their way back to England. After spending two years in the routines of frontier garrison duty, they had received orders to return. Major Henry Bassett, commandant at Detroit, and Captain John Vattas, commandant at Michilimackinac, were happy to leave those isolated posts on the farthest edges of the British Empire. Captain Vattas had had an active command at Michilimackinac where he erected the King's Storehouse and replaced 800 pickets around the stockade. His men worked to repair the fort with more than ordinary zeal; rumors swept the frontier almost weekly that Indians were on their way to surprise and capture the fort — as they had done 10 years earlier in 1763. The murder of several lone traders in the region only heightened the British worries.

"Major Bassett at Detroit was also fearful of Indian attack and steadily concerned by the general ill health of his soldiers. The western country seemed such a desolate place. Even British dreams of mining a fortune in copper along the south shore of Lake Superior had come to naught by 1773. Thus, when Captain Vattas received a letter from his Commander in Chief, General Thomas Gage, dated December 26, 1773, informing him that 'your Regiment is to be sent to England next Summer, and that the relief will take place as Early in the Season as the Navigation of the Lakes will permit,' he let out whoops of happiness.

"When the summer of 1774 arrived, true to the British plan, the King's Eighth Regiment replaced the Tenth as the Empire's troops in Michigan. The Eighth, in fact, remained in Michigan throughout the

TWO HUNDRED/*Continued*

entire Revolutionary period, while the men of the Tenth sailed east along the lakes toward their bloody destiny. Having been scattered at several posts along the frontier, the 477 men of the Tenth finally assembled at Quebec. They came from Michilimackinac, Detroit, Niagara, and Fort Erie, and all were happy to be going home.

"But instead of boarding ship for England, they found that "due to disturbances in Boston" they were not going to England after all. One soldier wrote home on September 20, 1774: 'Having just got settled in quarters, arrived an express from Boston with order for the Tenth and the Fifty-Second Regiments to embark immediately for Boston on the arrival of transports which are on their way for this place and hourly expected . . . Accordingly, on the 6th October we embarked and on the 8th set sail. We had a very rough passage, as would naturally be expected at that season of the year.' They arrived in Boston on November 3, but stayed on their cramped boats until the 27th.

Michigan affected

"Back at Michilimackinac, the outbreak of the Revolution produced little immediate affect. While the men of its former garrison were being shot to pieces on the Concord road, and later suffering slow death in Boston, their replacements at Michilimackinac were hardly aware that a war had started. For all they knew, the rebellion seemed only a bit of trouble stirred up by a few radical colonists. Not until July 4, 1776, when all 13 colonies proclaimed their independence, did the inhabitants at Michilimackinac begin to realize what might lie ahead. Not that they would suffer much violent action out here in the wilderness. On the contrary, throughout the years of the American Revolution, the area which is now Michigan remained staunchly loyal to the English crown.

"Yet the rebellion which engulfed the soldiers of the Tenth on April 19, 1775, also eventually swallowed up Michigan too. At the peace settlement in Paris in January, 1783, which ended hostilities of the Revolution and recognized the independence of the United States, Detroit and Michilimackinac were included in the new nation. By the stroke of a pen, Michigan died British and was born American. Thus, that rattle of shots fired on the green in Lexington by soldiers of the Tenth British Regiment eventually caused the Stars and Stripes to replace the Union Jack on the flagpoles of Detroit and Michilimackinac. And, ironically, they were the same soldiers who had guarded those flagpoles for the Empire —just 202 years ago this spring."

It should be remembered that many Americans 200 years ago were Loyalists who were forced to emigrate to Nova Scotia, New Brunswick and other parts of Canada as did some of my own ancestors. Also, some Loyalists moved back to the British Isles, to the western frontiers, to Sierra Leone on the west coast of Africa (Black Loyalists), and to the Bahamas. It is of interest that many white descendants in the Bahamas still Loyalist in sentiment, advocated becoming a separate Crown Colony when the rest of the Bahamas recently became independent from Britain on July 10, 1973, less than four years ago.

Thus every story of historic interest has two sides. The passage of centuries allows a more dispassionate appraisal of the issues over which wars were fought.

Our own revolution produced some great American poetry and a lot of American pride. Still, one feels now some sadness for the families and the men on either side of the question of American Independence.

Your dues support democracy

By Henry J. Klos, MD
Benton Harbor

Membership in organized medical societies is voluntary. It is the meeting of one's responsibility to fellow physicians.

In this state, the MSMS is the strongest voice of medical physicians and our dues finance that voice. Those who are not members of the MSMS are coasting on the efforts of those who are members. Without the MSMS there would be no effective coordinated effort to present the physician's view to the legislature, to Michigan bureaucracy (as Medicaid) nor other third party payers (as Blue Cross-Blue Shield). Although some of us may feel that government has been pushing the medical profession around, without a unified voice this pushing could easily have become crushing.

On a national level, the AMA has been the target of greatest dissatisfaction because of its reactionary and nonconstructive approach to health care delivery. There are increasing signs of a response to this dissatisfaction. However, these dissatisfactions should not obscure the many other essential functions of the AMA for which most of the money goes. These include the maintenance of high standards in medical education, collection of statistics both in the health and manpower field, publications, the representation of competent medical testimony on health legislation, etc.

Failure to support organized medicine because of philosophical disagreements is a violation of democratic principles except under the most extreme circumstances. We work with democratic principles when we participate to change our organizations.

Doctor Klos is editor of the Berrien County Medical Society Bulletin.

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Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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Warnings: **Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used.** Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K^+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy.** Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium® (triamterene, SK&F Co.), and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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The malpractice situation today — a progress report

By Elmer White
Special to Michigan Medicine

It is still too early to tell a great deal about changes in the malpractice/maloccurrence picture since new laws were enacted last year, but these facts or trends seem to be emerging:

- **The medical profession has been able to function and has made adjustments which permit it to continue to provide medical service.**
- **Cost of medical service has increased as a direct result of working within the new framework of legal threats.**
- **Much valuable data can now be collected from reports required by law. Analysis of these will permit MSMS to pinpoint trouble areas in providing medical service. "Risk management" becomes a new insurance term.**
- **The number of malpractice suits has not lessened; the number of claims has increased by 19%.**
- **Doctors are practicing more "defensive medicine" and work under increased pressures to perform perfectly at all times.**
- **MSMS is taking steps designed to remove MDs from aspects of the Brown-McNeely Fund which permit assessment against all doctors for needed settlements if funds run short.**
- **A new concept is developing to describe what happens when there is unexpected difficulty in patient recovery. It differs from "malpractice" because the difficulty could reasonably be anticipated. The new term is "maloccurrence," and the new expression makes a great difference to doctors who should not be blamed when recovery is less happy than expected.**
- **Doctors are now required to earn at least 50 credits each year in educational processes which expand or update medical knowledge.**

Perhaps the obvious conclusion in reviewing recent professional liability developments is that society and the medical profession have found a way to live through the recent crisis so that medical service can still be provided.

But a major result has been that the cost of health service has now increased substantially. The public is paying the increase through higher health insurance rates and larger tax burdens.

There are signs now that the number of large settlements has decreased, although the situation has the same potential for eruption as a volcano.

There also are signs that the substantial increase in malpractice insurance rates has leveled off. Doctors can expect to allocate between $1.25 to $2 of the bill charged to each patient for insurance expense. The amount varies by specialties.

One important benefit of the malpractice insurance experience is that great amounts of new information now are available. The new data permit analysis which simply could not be made previously.

Analysts can now record the number of claims filed, the plaintiffs, the claims made and the settlements agreed upon. They hope to identify what triggers some kinds of claims and the specialties of doctors involved; the costs for attorneys, at what stage settlement is made and "who won." Present figures show, for example, that only between two and three percent of claims actually go all the way through the court, and of those, 75% are settled in favor of the physician.

These statistics help with a relatively new activity in medical insurance: "risk management." Researchers at MSMS already are at work to find common threads among maloccurrences. It is expected that the number of claims can then be reduced by advising doctors on high-risk procedures, by pressing insurance companies to change their requirements or procedures, and by helping doctors make better peer review judgments.

Other circumstances which have come into being since the malpractice crisis:

(1) Doctors have been forced to practice defensive medicine. The result is sizable increases in lab and X-ray costs. It is a discomforting note to see that an extreme majority, over 90%, of skull X-rays are negative, according to the MSMS Bureau of Economics. It is also understandable that the service should be ordered as a defensive maneuver.

(2) The Michigan medical arbitration procedure has been designed to deal more promptly with claims concerning malpractice or maloccurrence. This machinery is optional with the patient and has not, as yet, resulted in great activity. As of January, 1977, only two cases were listed in the arbitration stage.

(3) More careful peer review should result, though it is difficult to say that it has. Competent doctors have every reason to check carefully any claims or charges of dissatisfaction in the delivery of medical service. And the new law gives physicians immunity from liability while performing peer review in hospitals.

Mrs. Dixon

MSMS Auxiliary helps doctors; doctors can help Auxiliary grow

By Ruth K. Dixon
Grand Rapids

In this age of humanism, public opinion polls consistently indicate that physicians are held in the highest esteem among professionals. At the same time, we recognize a steady erosion in this trust and confidence, due, to a significant degree, to the ever-increasing encroachment of governmental forces.

Because it is not humanly possible for the physician to devote himself/herself to all the community concerns that claim the heart and mind, the medical auxiliary has become an effective public relations tool to extend the physician's efforts for societal good.

The fundamental purpose of the MSMS Auxiliary is to assist the MSMS in programs to advance medicine and health education. With this charge, and from my vantage point as president, I am privileged to know that the auxiliary is indeed moving forward with its programs to improve health care in Michigan.

The MSMS Auxiliary was organized in 1926, just four years after the founding of the national auxiliary. Even though, in the begining, the primary consideration was to broaden acquaintanceship between physicians' families, there was early activity commensurate with interests physicians themselves could not find time to manage. As auxiliary membership grew, so also did the extent of community service that could be accomplished. WWII made our spectrum deeper, broader, more all-encompassing than previously. With this basis for direction, the MSMS Auxiliary centered its thrust on providing community service.

For over 50 years, auxiliary members have demonstrated their dedication and devotion to a common purpose, proving by deeds how deeply they care for their fellow man. They recognize that identity and independence are coupled with a necessary interdependence, and, by interacting one with another, there is a vast reservoir of shared, visible concern and knowledge. Our members are encouraged to participate actively with other community service groups in our pursuit of community betterment. In essence, our concerns range the gamut of living; our aim is to improve the quality of life through a healthy mind, in a healthy body, in a healthy environment.

Auxiliary emphasis on programming in health, health education, legislation and health manpower involves not only local and state concerns but national and international issues, as well. We are attuned to the priorities of the medical society and are anxious to be helpful when needed.

There are many potential participants that the auxiliary would hope to convince to join in our sense of purpose. The individual member is the heartbeat of the auxiliary; strength lies in numbers, however. Of 83 counties in Michigan, only 43 are organized into 32 auxiliary groups. There are 56 members-at-large.

There are but four considerations for organizing a county auxiliary: (1) Endorsement by the county medical society; (2) More than one member; (3) Bylaws for governance; (4) Dues, amount determined locally but to include the state portion (currently $2) and the national dues ($7).

In our quest for a wider representation of all physicians in Michigan, for new ideas and new talents and new ways to do things better, I am appealing to physicians whose spouses are not now a part of the MSMS Auxiliary. We would urge them to be sure their mates join us.

Membership affords the opportunity for constructive self-expression, a chance to see ourselves as others see us in the role of concerned and active citizens on the physician's behalf. The public expects no less.

Mrs. Dixon is president, MSMS Auxiliary.

Dental health flyers available

A series of five, one-page flyers are available from the Michigan Dental Association to help physicians guard the dental health of patients.

They are entitled, "Healthy Teeth For Your Baby," "Your Child's First Teeth," "Clean Your Teeth — Why?", "First Visit to the Dentist," and "Carrots or Caramels."

Single copies available free. Additional copies are 3¢ each. Write: Michigan Dental Association, 230 North Washington Square, Lansing, Michigan 48933.

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androgenic deficiency
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Android®-5 Buccal Tabs
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* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; + + = 50% improvement; + + + = 75% improvement. Placebo effectiveness was + or + + in 12.7% of trials. Android-25 elicited a +, + + or + + + response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION**: Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the mate:** Eunuchoidism and eunuchism, 10 to 40 mg., Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg., Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974 **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.** 2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Write for Reprints and Samples.

". . . availability of prenatal diagnostic services . . ."

The Michigan State University Department of Obstetrics, Gynecology and Reproductive Biology, and the Department of Human Development announce the availability of Prenatal Diagnostic Services at Michigan State University. The service includes screening for specific genetically-transmitted disorders listed on the enclosed table. Women 35 years or older also should be considered for referral. It frequently is useful to refer patients before a decision has been made, since the preliminary counseling session usually assists patients in reaching an informed, intelligent, unemotional decision.

Appointments can be made through James Higgins, MD, or Ms. Sharon Koehler at (517) 353-2030. Patients customarily can be seen promptly. This MSU service is available at East Lansing, Grand Rapids and Flint.*

An initial interview will be scheduled to outline a diagnostic program, assess the couple's emotional needs and to answer questions. The clinic is offering primarily a diagnostic service, not chromosomal or biochemical analyses on submitted specimens. Preferably, patients should be seen prior to the onset of pregnancy, but they can be seen as late as the 18th or 20th week after the last menstrual period. It should be emphasized, however, that it is easiest on the patient if she is referred early. It should also be emphasized that we are only offering a diagnostic service and would expect the patient to continue with her referring physician for care unless the referring physician feels this is inappropriate. The referring physician might prefer MSU to continue care if a fetal abnormality is verified.

The clinic fee, reimbursable by several third party carriers, is a fee for service and should not exceed $450 including laboratory and physician charges. The charge for initial interview during which time the problem is assessed and the diagnostic procedures outlined is included in the above fee if the couple elects to go ahead with amniocentesis. Otherwise, there is a $50 counseling fee. In those cases where the couple cannot afford payment, every attempt possible will be made to obtain financial support from alternate resources.

There are many inheritable diseases where a specific in-utero diagnosis cannot be made. These patients often benefit by pre-pregnancy counseling since risk factors are discussed. These couples will be charged routine laboratory fees usually reimbursable by third party carriers.

Gerald B. Holzman, MD
East Lansing

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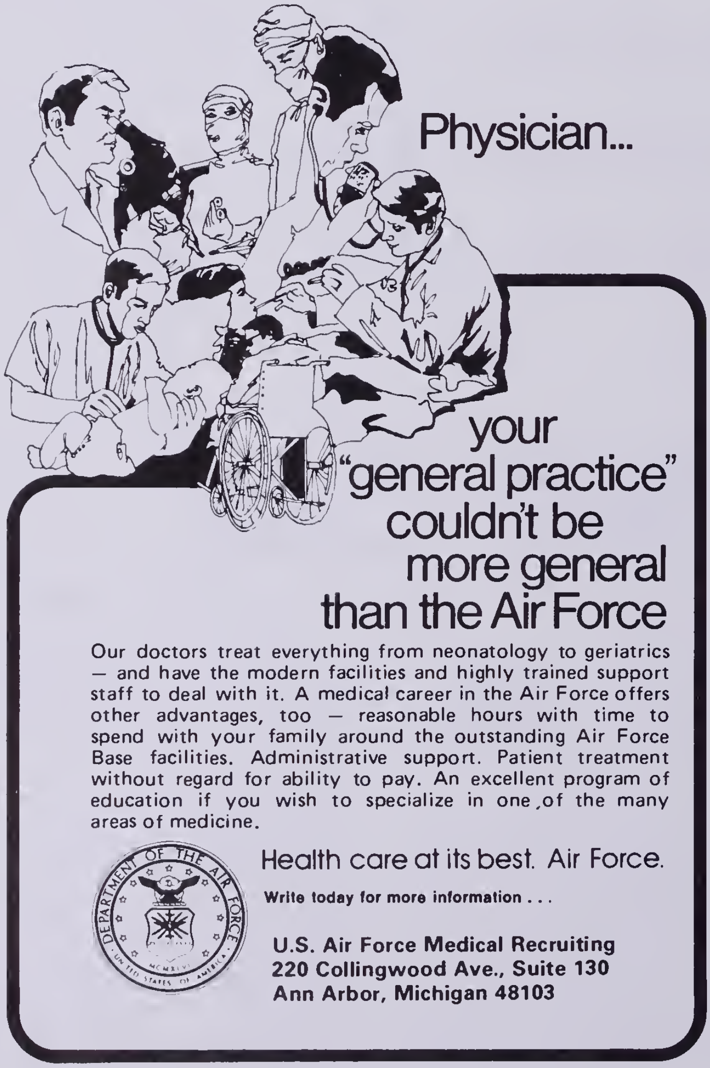
*(Similar consultation is available in the Detroit area at Wayne State University or Henry Ford Hospital or in the Ann Arbor area at the University of Michigan.)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". . . to promote education . . . in biofeedback"

On behalf of the membership and the Board of Directors, I am pleased to inform you of the establishment of the *Biofeedback Society of Michigan, Inc.* Our Society is an organization of individuals who are working to promote research and professional applications in biofeedback. Accordingly, we represent a wide range of disciplinary interests such as medicine, psychiatry, psychology, physical therapy, education, engineering, and other areas.

It is our feeling that although much research remains to be done, biofeedback has been found to be of use in a number of ways, both medical and non-medical. Therefore, a principal goal of ours will be to promote education in the area of biofeedback and self-regulation and to provide opportunities for professional training.

For additional information contact our Secretary/Treasurer, Dr. James D. Papsdorf, Department of Psychology, University of Michigan, Ann Arbor, Mi. 48109.

Richard R. Williams, PhD
President

". . . Placental . . . Registry is to continue . . ."

The Michigan Placental Tissue Registry, originated by the late Joseph R. Cipparone, MD, is to continue at Michigan State University.

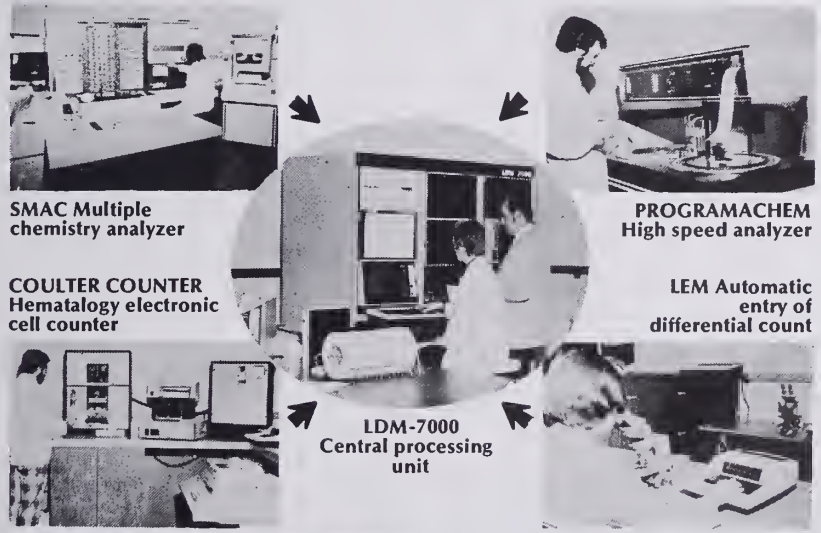
The registry, sponsored by the Michigan Department of Public Health, is a division (subcommittee) of the MSMS Committee on Maternal and Perinatal Health. Charles Sander, MD, and Henry Kallet, MD, Michigan State University Department of Pathology, direct the registry, which receives placentas from hospitals throughout Michigan. Lawrence Nathan, MD, has served as an interim director since Doctor Cipparone's death.

The registry acquires pathologic placental tissue specimens and disseminates the knowledge gained by a study of these specimens to those concerned with the care of the pregnant patient and her child.

Michigan physicians are encouraged to continue their support of this important function by sending placental specimens to Charles Sander, MD, Department of Pathology, A630 East Fee Hall, Michigan State University, East Lansing, MI 48824.

Charles H. Sander, MD
Professor and Associate Chairman
MSU Department of Pathology

AMRC Computerized Laboratory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". . . a disgraceful undeserved restriction . . ."

I am very disgusted with the deal handed our state medical society by our legislature. I am referring to the imposition and requirement of 50 hours of prescribed post-graduate lectures in order for us physicians to qualify for renewal of our license to practice medicine. This is probably commendable for doctors who are in active clinical practice, however this imposes an inexcusable burden on members of our profession who are in non-clinical areas of service to the state.

I believe that the most flagrant hardship imposed on our profession lies among our retirees. As the law now stands when a physician retires he automatically loses his license. This imposes a disgraceful undeserved restriction of privileges. When a doctor has given good services to his community for 20 or 50 years, there is no valid excuse for taking away his ability to even write a prescription for his spouse.

Retirement should not mean curtailment of all privileges of his profession. To require 50 hours of post-grad study for the privilege of writing a prescription for routine medication for a spouse is asinine in my opinion. It is understood that for major medical attention, a married partner would have the benefit of another physician's care. However it would be embarrasing and humiliating to impose on an active colleague for simple routine care.

In all other areas, as corporations, state and municipal employees, retirees are treated with respect, honored and financially remunerated. However in our great profession all we receive is a stab in the back. This is regrettable, irresponsible and reprehensible treatment by our legislature. I believe that this inexcusable faux pas should be promptly remedied by our legislature.

R. E. Kalmbach, MD
Lansing

". . . you have done an excellent job . . ."

Thank you very much for the two complimentary copies of the January issue of *Michigan Medicine*. I reviewed the article on page 31, and you have done an excellent job in handling this for me.

Neal L. McCue
Vice President,
Professional Relations
Blue Cross/Blue Shield of Michigan

". . . pleasant memories of my 'medical roots' . . ."

To read about and see pictures of the men active in the profession now (in *Michigan Medicine*) brings back pleasant memories of my "medical roots" — teachers and colleagues active in my time, 1919-1972, all highly esteemed and now departed for their "eternal rest." I am proud of my medical heritage. Greetings and best wishes to all.

H. L. Perlis, MD
WSU College of Medicine
(Detroit College of Medicine
and Surgery)
Class of February, 1919

". . . an update on the activity of SHOTS . . ."

I am responding to your request for an update on the activity of the Statewide House Officers Training System. Let me start by a short review of past history.

Our recently-incorporated Task Force has on its board of directors representatives from the Michigan State Medical Society, the Michigan Association of Osteopathic Physicians and Surgeons, Michigan Association for Medical Education, Michigan Blue Cross/Blue Shield, Michigan Hospital Association, Michigan Medical School Council of Deans, Michigan Osteopathic Hospital Association. In addition, we have a representative from the Governor's Office of Health and Medical Affairs.

The purpose of the organization is to better meet the physician needs of Michigan through improvements in graduate medical education which complement, but in no way replace the activities of existing national accrediting and certifying bodies.

The first goal we have attempted to address is to increase the number of primary care physicians in the State of Michigan by increasing the number of residents training in primary care in the State. Program Advisory groups in the four primary care specialties have met, and through various activities are attempting to further improve the quality of their programs in hopes of attracting more residents.

Recently, the SHOTS Board of Directors decided that they would attempt to address a second goal, the improvement of the geographic distribution of physicians in Michigan. This decision was made in January. The initial efforts to achieve this goal will be made through primary care program advisory groups. All three of these groups met in February.

On behalf of SHOTS, let me thank you and the membership of the Michigan State Medical Society for their continued interest and support.

Robert B. Carbeck, MD
Executive Director,
SHOTS Task Force

Council resolution praises Brock E. Brush, MD

Doctor Brush

The MSMS Council will honor Brown-McNeely Fund Board Chairman Brock E. Brush, MD, with the introduction of the following resolution at the 1977 MSMS House of Delegates meeting May 13-15 in Troy:

WHEREAS Brock E. Brush, MD, beloved and admired past president of the Michigan State Medical Society, has been chairman of the Brown-McNeely Fund since his appointment by Governor William Milliken in 1975; and

WHEREAS he has spent countless hours studying the many complex aspects of the Brown-McNeely Fund, created in 1975 by the Michigan Legislature to help make professional liability insurance available for physicians unable to obtain coverage from commercial firms; and

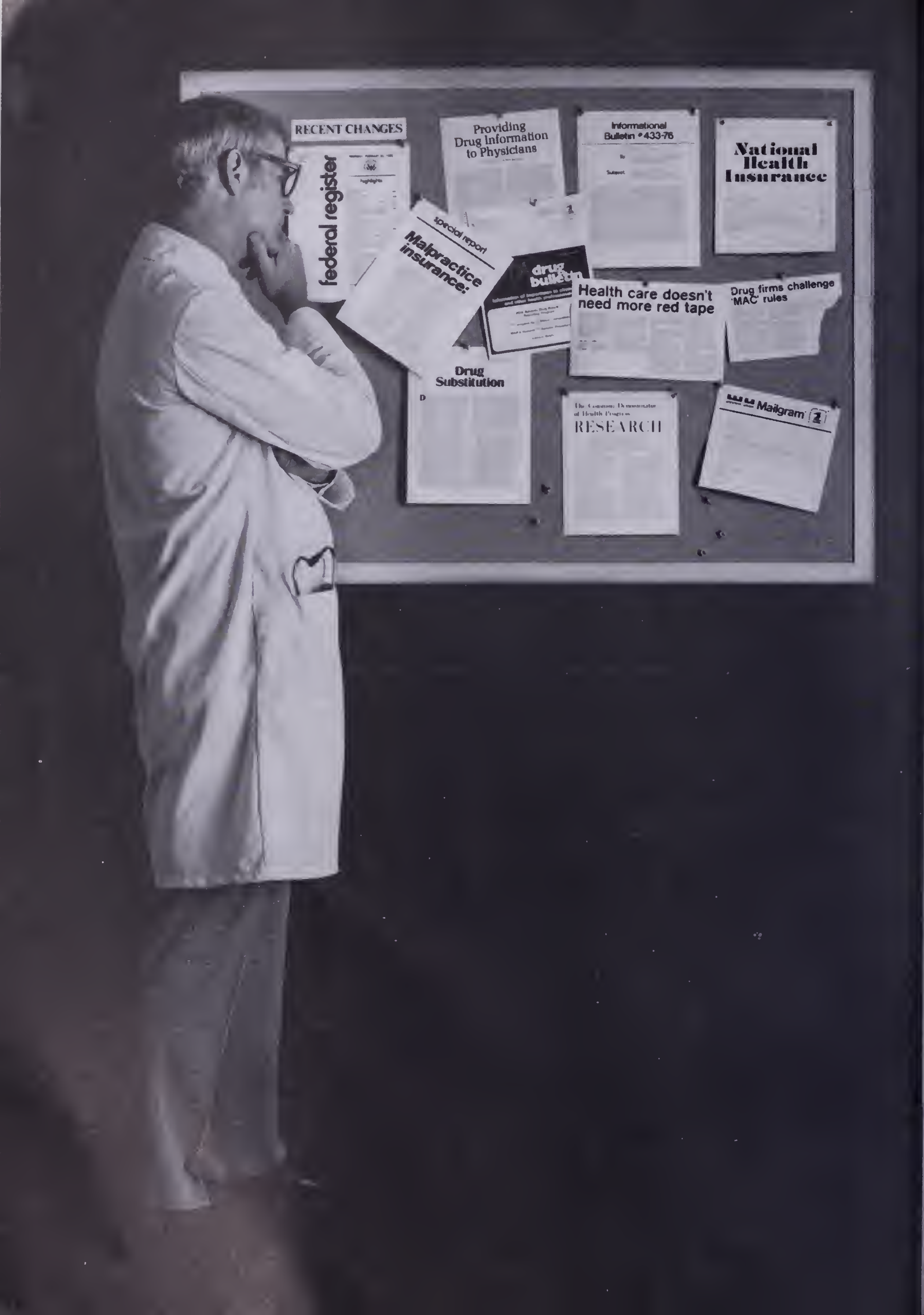
WHEREAS he has presided at meetings of the Brown-McNeely Board with dignity and objectivity; and

WHEREAS he has strived to have the Fund operated fairly for every physician in Michigan; and

WHEREAS he has insisted that the Brown-McNeely Fund be conducted in a responsible and business-like manner to avoid any deficits that would result in assessments against all Michigan physicians who carry liability insurance whether with the Fund or not;

Therefore be it RESOLVED that the MSMS House of Delegates voice its sincere appreciation to Brock E. Brush, MD, for his distinguished service as chairman of the Board of the Brown-McNeely Fund, and sincerely offer the heartfelt thanks of the physicians of Michigan;

And be it further RESOLVED that a copy of this resolution be sent to Governor Milliken in order to demonstrate the high esteem that physicians hold for Doctor Brush as a dedicated public servant and surgeon.


RECENT CHANGES
federal register
highlights
Providing Drug Information to Physicians
Informational Bulletin #433-76
Subject
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Deciding to incorporate like buying a home

By William D. North
Chicago

(This article is excerpted from a talk the author presented at a recent annual meeting of Professional Management Associates of Michigan.)

The experience I find most relevant to the decision to incorporate is the decision to buy a home. A home is "shelter" and incorporation is, in fact, a shelter for the professional's business.

My friends in the real estate business tell me there are basic needs to be considered in the purchase of a home. So too, the decision to incorporate will be influenced by the professional's perceived needs. I believe the professional corporation is, beyond any question, the best means available to the professional of satisfying the following needs:

(1) The threat of living too long, dying too soon, or losing earning capacity too early.

(2) The effective and efficient conduct of his business or practice.

(3) The professional sees his/her future in a group practice.

Affording incorporation

But having needs and being able or willing to afford to satisfy them are frequently two different things.

So how do we know if our professional can afford the corporate shelter?

The answer depends upon one figure—the difference between what the doctor makes and what she/he must spend to maintain the desired life-style.

If the physician realizes she/he can take advantage of tax savings on retirement plan contributions, on disability income and group term insurance premiums, on ordinary life insurance premiums held by the retirement plan trustees, but still doesn't feel she/he can put away more than $7,500 a year now or in the foreseeable future, she/he is unqualified to purchase a corporate shelter.

There is one other reason why a professional may be unable to afford incorporation—a very large collateral payroll (the payroll of employees other than the professional who owns the business).

My general rule is: If the aggregate collateral payroll is equal to or exceeds the aggregate payroll of the owner employees, incorporation is probably unaffordable unless the number of owner-employees is significant.

Psychological factors

Let's continue. There is a very definite psychological factor which enters into the decision to buy a corporate shelter.

If a professional would insist on operating out of his "hip pocket," on mixing business and personal affairs, on viewing the trust funds as personal investment accounts, she/he is best off out of a corporate shelter and into a proprietorship or partnership.

Further, it is inadvisable to seek a corporate shelter until the professional is reasonably settled into business or practice and satisfied with its prospects.

If the professional perceives his/her situation as reasonably permanent, the next consideration is the resale value of the proposed corporate shelter. Most of the professionals I have met who are the most apt candidates for incorporation view their practices and businesses as going concerns; as something which they have built which should continue beyond their professional lives.

There is a strange and I think wonderful metamorphosis which seems to take place with a sound incorporation. The professional starts talking and thinking about the corporation as something independent. She/he starts seeking new talent; expands the scope of practice; starts planning how this going concern can keep going.

And she/he may justifiably think of these things because the resale value of a corporate shelter can be significant, especially compared to the proprietorship. A properly structured professional corporation can attract new professionals as no other form of professional practice can and thereby assure optimum going concern value on resale.

The future

Of course, before anyone buys a house they want to know about the neighborhood—is it going up or going down? The same questions are of concern to the professional considering incorporation. What are the prospects for the professional corporation?

If I were to make a prediction I would bet on the future of the professional corporation to the ultimate exclusion of most other forms of professional practice, because:

(1) As real estate, drilling, capital gains, and other tax shelters are eliminated by periodic tax reform, utilization of the shelters available through incorporation becomes the

(Continued on next page)

Mr. North is a partner in Kirkland and Ellis Law firm, legal counsel to physicians.

Next MSMS practice management seminars in June

The highly-successful series of MSMS seminars on practice management wil continue with four more in-a-row June 7-8-9-10 in Detroit, Troy, Lansing and Grand Rapids, respectively. The June meetings will be for physicians well established in practice. The photo at left, was taken during the most recent seminars. Leader George Conomikes, right, professional management consultant from California, will return for the June seminars. Further information is available from the MSMS Bureau of Economics.

How health dollars were spent in 1976

The following figures represent national health expenditure highlights for fiscal year 1976, as reported by the Office of Research and Statistics, Office of Program Policy and Planning, Social Security Administration.

- Total U.S. spending for health care reached $139.3 billion, or a per capita expenditure of $683.
- The 1976 total represented a 14 percent increase over the revised estimate of $122.2 billion spent in fiscal 1975.
- In the 2 years since price controls on the health industry were lifted, estimated expenditures have risen $33.0 billion or 31.0 percent.
- Meanwhile, the economy in general has grown at a relatively slow pace. The GNP has increased by 18 percent in these 2 years. As a result, health spending as a percent of GNP has grown from 7.8 percent in 1974 to 8.4 percent in 1975 and up to 8.6 percent in 1976.
- Public spending increased substantially — up 15.6 percent. However, this was well below the 22.5 percent increase in 1975. Private spending rose by 12.8 percent, somewhat above the growth rate in the previous year.
- Hospital care expenditures of $55.4 billion, at nearly 40 percent of total spending, remained the largest expenditure category. This level was 15 percent above that estimated for 1975.
- Expenditures for physicians' services, estimated at $26.4 billion, were nearly half as large as hospital expenditures. The figure for physicians' services represented an increase of 15 percent over 1975 expenditures.

INCORPORATING/*Continued*

only alternative available to the affluent professional;

(2) As administrative costs of professional practice increase, prepaid legal, dental, and medical programs expand and specializations narrow, professional services will have to be rendered on a group as opposed to an individual basis.

(3) Without a major turnaround in the availability of professional liability coverage, access to professional practice may well depend upon access to a going concern with such insurance and an established rating;

(4) As more and more professionals become incorporated the psychological barriers to the corporate form will decline and it will become the norm.

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Salma Aftab, MD
3800 Woodward Ave., #208
Detroit 48201

William C. Albert, MD
26206 W. 12 Mile Rd.
Southfield 48034

O. Rodolfo Argueta, MD
2201 Medford Rd.
Ann Arbor 48104

Ronald M. Benson, MD
2200 Fuller Rd., #203B
Ann Arbor 48104

Owen M. Berow, MD
1324 S. Park
Kalamazoo 49001

George G. Bruzza, MD
1634 Gull Rd.
Kalamazoo 49001

C. Dennis Bucko, MD
221 N. Ingalls
Ann Arbor 48104

I. Dale Carroll, MD
111 W. Dayton St.
Fremont 49412

Franklin H. Castillo, MD
4811 Venoy Rd.
Wayne 48184

Eung R. Choi, MD
917 W. Oak
Greenville 48838

Michael J. Crawford, MD
6159 Del Cano, SE
Grand Rapids 49506

Stephen J. Dreyer, MD
300 E. Chicago St.
Coldwater 49036

Richard D. Dryer, MD
15101 Southfield
Allen Park 48101

Fereshteh Fahimi, MD
802 Cherry Lane #201
East Lansing 48823

Royouk A. Farvar, MD
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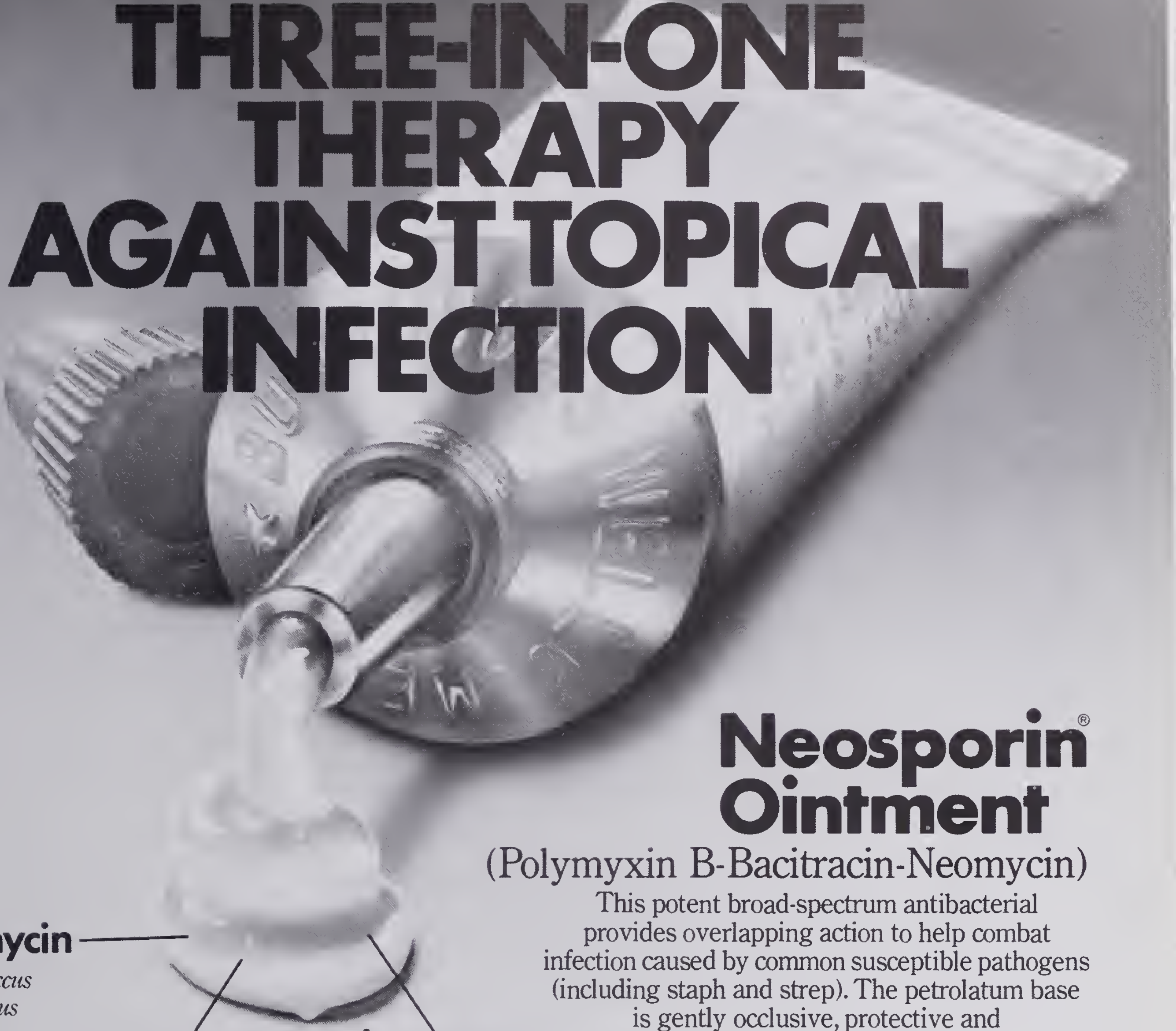
Brutus 49716

(Continued on page 200)



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This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

Neomycin	**Bacitracin**	**Polymyxin B**
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Escherichia		*Escherichia*
Proteus		
Corynebacterium		
Streptococcus		
Pneumococcus		

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North Carolina 27709

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Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

MONTHLY SURVEILLANCE REPORT

Cases of Certain Diseases
Reported to the Michigan Department of Public Health

For the four-week period ending Feb. 25, 1977

	1977 This 4-Week Period	1976 Same 4-Week Period	1977 Total To Above Date	1976 Total Same Date	Total Cases for 1976
Rubella	121	161	175	249	1,513
Cong. Rubella Syndrome	0	0	0	0	2
Measles	118	260	207	311	6,139
Whooping Cough	2	13	3	20	70
Diphtheria	0	0	0	0	0
Mumps	304	789	486	1,386	5,507
Scarlet Fever & Strep Sore Throat	3,140	2,765	6,039	4,815	24,937
Tetanus	0	0	0	0	3
Poliomyelitis (paralytic)	0	0	0	0	1
Hepatitis	245	191	518	381	2,645
Salmonellosis (other than S. typhi)	66	78	162	125	889
Typhoid Fever (S. typhi)	2	0	4	0	10
Shigellosis	34	44	77	79	550
Aseptic Meningitis	8	3	15	17	163
Encephalitis	3	10	8	15	77
Meningococcic Meningitis	3	6	6	12	65
H. Influenza Meningitis	16	9	25	20	134
Tuberculosis	138	99	216	183	1,357
Syphilis	98	100	176	188	1,066
Gonorrhea	2,380	2,385	4,778	4,995	34,829

Information can be supplied by the local health department on local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

WELCOME/*Continued*

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Cadillac 49601

WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE ALUMNI ASSOCIATION

109th Medical Alumni Reunion Day
Wednesday, May 11, 1977

The Hyatt Regency, Dearborn

Registration: 8:30 a.m.
Lunch: 11:45 a.m.
Alumni and Student Awards

Professional Sessions*
Reception: 6 p.m.
Dinner and Entertainment: 7 p.m.
Gold and Silver Anniversary Awards

PANEL DISCUSSIONS:
Trends in Diagnosis and Treatment of Infection 9:30 a.m.-11:30 a.m.
Environmental Impact of Federal Consumer Protection 1:30 p.m.-3:00 p.m.
Ethical-Moral Aspects of Medicine 3:15 p.m.-4:45 p.m.

Reception 6 p.m.
Dinner and Entertainment 7 p.m.
Gold and Silver Anniversary Awards
For more information call WSU School of Medicine (313) 577-1495

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*Application has been made for Category I credit

The ethics of insurance exams

The following is another in the series of recent opinions on medical-legal problems of general interest provided by MSMS Legal Counsel for MSMS members. It has been adopted somewhat from the original opinion. This material is intended only to inform and should not be used to resolve legal problems.

Recently, an Upper Peninsula physician asked MSMS Legal Counsel the following questions:

1. Does a physician examining a patient for an insurance company have an obligation to report his interpretation of the findings to the patient or does this obligation exist only with the insurance company?

2. What are the ethics involved in a case when an examining physician for an insurance company recommends treatment, and further surgery to the patient, without the knowledge or consent of the attending physician.

Legal Counsel replied:

The second question, on ethics, is something that perhaps I should leave to the ethics committee of your county society or to the MSMS Judicial Commission. My knowledge is limited to the Judicial Council opinions of AMA, which I here quote:

> "7. RELATIONSHIP WITH ANOTHER PHYSICIAN'S PATIENT: A physician, in his relationship with a patient who is under the care of another physician, should not give hints relative to the nature and treatment of the patient's disorder; nor should a physician do anything to diminish the trust reposed by the patient in his own physician. In embarrassing situations, or whenever there seems to be a possibility of misunderstanding with a colleague, a physician should seek a personal interview with his fellow.";
>
> "9. SERVICES TO PATIENT OF ANOTHER PHYSICIAN: A physician should not take charge of, or prescribe for another physician's patient during any given illness (except in an emergency) until the other physician has relinquished the case or has been formally dismissed."

If these opinions do not precisely fit your facts, feel free to make the contacts above suggested.

In partial answer to the first question, there is still no Michigan law extant on the subject. I am told that a case involving Johns-Manville Co., concerning something close to or resembling your facts, was recently decided at a lower court and jury level in California. That case would not be a precedent in Michigan but the case is interesting in that the California court evidently said the physician must inform the worker of his illness even though the insurance company or the employer company is paying for the services.

Ohio malpractice act unconstitutional

(The following is taken from the AMA publication, The Citation, *Vol. 34, No. 7, Jan. 15, 1977).*

The pleading requirements, limitations on the amount of damages recoverable, and compulsory arbitration sections of the Ohio Medical Malpractice Act are unconstitutional, an Ohio trial court ruled.

Alleging malpractice, a patient at a medical center sued the medical center for $200,000 in damages. As part of the lawsuit, the patient challenged the sections of the Ohio Medical Malpractice Act dealing with the special pleading requirements, the $200,000 limitation on recovery, and the compulsory arbitration provisions as being unconstitutional.

The sections of the Malpractice Act were challenged on the basis that their requirements denied persons wishing to file a malpractice lawsuit equal protection of the law by limiting them in the amount of damages they could recover, and denying them the right to a trial by a jury by forcing them to submit their claim to an arbitration board.

The medical center argued that these limitations on the rights of individuals wishing to maintain a malpractice action are more than justified by the crisis that exists in Ohio and other states in the areas of health care and medical malpractice insurance. The medical center felt that the rights of the individuals to get as much money as wanted was subordinate to the need to put some curbs on the skyrocketing costs of medical malpractice insurance and the corresponding soaring costs of health care to the community as a whole.

The trial court rejected the medical center's theory and held the sections of the Ohio Medical Malpractice Act unconstitutional.

"There is no doubt that the plethora of medical malpractice suits represents a crisis situation, not only to the medical profession but to their insurance carriers as well. However, in this court's opinion, there is no crisis situation, short of civil insurrection, sufficient to deprive, water down or make less valuable the right to seek redress of grievances, to a dollar amount fully compensating one for his loss, through the medium of a free and unfettered jury trial," the court concluded. — Simon v. St. Elizabeth Medical Center, 355 N. E. 2d 903 (Ohio Ct. of Common Pleas, Oct. 20, 1976)

Meetings

(See also Category I listings on page 207)

April 14 — 1977 Annual Michigan Conference on Medical Aspects of Organized Athletics, Towsley Center, U-M, Ann Arbor, contact: Herb Auer, MSMS headquarters.

April 14-17 — Annual Meeting, State of Michigan Branch, American Association of Medical Assistants, Kalamazoo Civic Center, Kalamazoo, contact: Mrs. Ginger Hyatt, Chairman, 2533 Cumberland St., Kalamazoo 49007.

April 20 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS director.

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April 19-21 — International Symposium on "Human Ovulation" at C. S. Mott Center for Human Growth and Development, Wayne State University School of Medicine, Detroit, contact: E. S. E. Hafez, MD, C. S. Mott Center.

April 21 — Michigan School Health Association Annual Conference, Long's Convention Center, Lansing, contact John A. Romas, c/o American Lung Association of SE Michigan, 28 West Adams, Detroit 48226.

May 3-5 — "Introduction to Data Retrieval and Display," Continuing Education for the Health Care Professional, Commission on Professional and Hospital Activities headquarters, 1968 Green Road, Ann Arbor, contact: CPHA, 313/769-6511.

May 6 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS director.

May 13-15 — 51st Annual Convention, MSMS Auxiliary, Michigan Inn, Southfield, contact: Mrs. F. P. Rhoades, 272 Ashland Avenue, Detroit 48215.

May 13-15 — MSMS Council, (during House of Delegates), Troy Hilton, Troy, contact: Warren Tryloff, MSMS director.

May 13-15 — 1977 Annual Session, MSMS House of Delegates, Troy Hilton, Troy, contact: Richard Campau, MSMS headquarters.

May 14 — May Seminar, "Lymphoreticular Disorders," sponsored by the Michigan Society of Pathologists at Hurley Hospital, Flint, contact: Jacob E. Briski, MD, Saint John Hospital, 22101 Moross Road, Detroit 48236.

May 16-27 — Health and Chronic Disease among the Elderly, Ann Arbor, contact: Dorothy H. Coons, director of continuing education, Institute of Gerontology, The University of Michigan-Wayne State University, 520 East Liberty, Ann Arbor 48109.

May 24-27 — Annual Meeting, Michigan Public Health Association, Park Place Motor Inn, Traverse City, contact: MPHA 517/484-3044 or James K. Edmunds, 313/577-1400.

June 13-17 — Speech, Language and Hearing Problems of Older Persons: Identification and Management, Ann Arbor, contact: Dorothy H. Coons, director of continuing education, Institute of Gerontology, University of Michigan-Wayne State University, 520 East Liberty, Ann Arbor 48109.

June 18-22 — AMA Annual Convention, San Francisco, contact: Warren Tryloff, MSMS director.

July 11-22 — Biology of Aging, Ann Arbor, contact: Dorothy H. Coons, director of continuing education, Institute of Gerontology, University of Michigan-Wayne State University, 520 East Liberty, Ann Arbor, 48109.

July 22-24 — MSMS Council, Deer Lake, Boyne Falls, Michigan, contact: Warren Tryloff, MSMS director.

August 6-10 — Annual Convention and Scientific Assembly of the Michigan Academy of Family Physicians, Sugar Loaf Mountain, contact: Rita Feldkamp, MAFP, executive secretary, 933 Wing St., Plymouth, MI 48170.

Sept. 7 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS director.

Sept. 17 — Michigan Society of Pathologists September Seminar, "Renal Disease," St. John Hospital, Detroit, contact: John F. Dunkel, MD, Department of Pathology, MSU, East Lansing 48823.

November 2 — MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS director.

November 8-10 — MSMS Annual Scientific Meeting, Dearborn Hyatt Regency, Dearborn, contact: Herb Auer, MSMS headquarters.

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Hearing losses are among the most consistently neglected health problems. Many people with them won't even admit it to themselves, let alone others. A little encouragement may start them thinking about themselves more realistically.

That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

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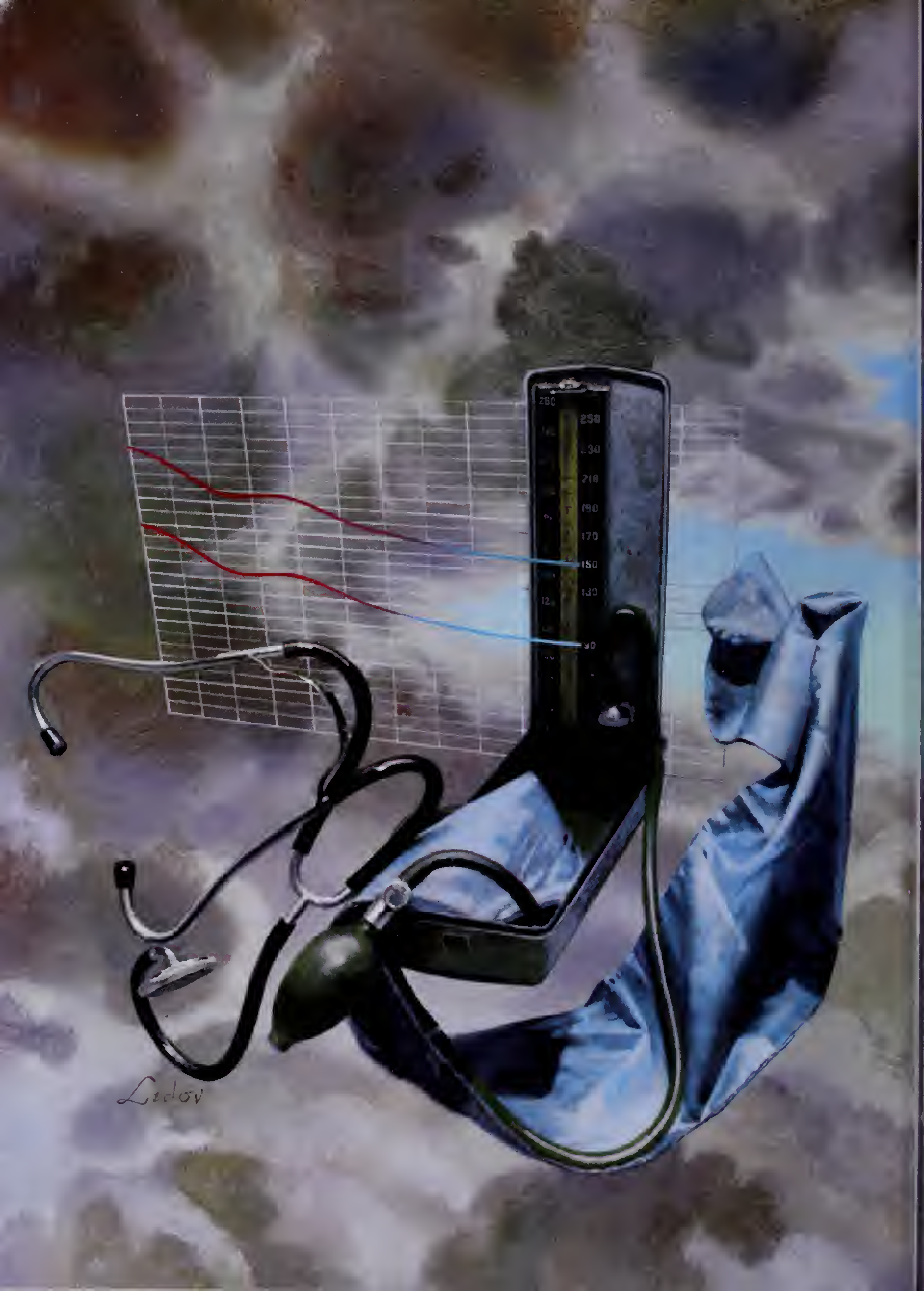
WHEN A HEARING AID WILL HELP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When choosing a diuretic for day-in-day-out hypertension control with comfortable compliance...

The agent you choose in mild to moderate essential hypertension should offer (1) long-term effectiveness, (2) patient comfort and compliance.

Zaroxolyn offers both.

In one long-term study[1] Zaroxolyn brought moderately elevated (average 161/109 mm Hg) blood pressure down to the range of normotension—and held it there for a year or more.

The investigator noted, "Patient cooperation was surprisingly good for a study of such duration [2½ years]. The once-daily dosage schedule with metolazone [Zaroxolyn] no doubt contributed to patient compliance."

Overall compliance with Zaroxolyn is good—very good. An analysis of controlled clinical studies involving 188 Zaroxolyn patients showed that only eight discontinued therapy because of side effects. That's a discontinuation rate of only 4.3%, and broader clinical experience appears to substantiate this low rate.[2]

Zaroxolyn. For long-term control and comfortable compliance in mild to moderate hypertension.

Recommended initial dosage in mild to moderate essential hypertension–2½ to 5 mg once daily

Zaroxolyn®

(metolazone, Pennwalt)

2½-mg, 5-mg and 10-mg tablets

once-daily antihypertensive diuretic

Before prescribing, see complete prescribing nformation in the package insert, or in PDR, or available from your Pennwalt representative. The ollowing is a brief summary **Indications**: Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents. Also, edema associated with heart failure and renal disease. **Contraindications:** Anuria, hepatic coma or precoma; allergy or sensitivity to Zaroxolyn. Or, as a routine in otherwise healthy pregnant women. **Warnings**: In heory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia Administration to women of childbearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk Not for pediatric use. **Precautions**: Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered Patients treated with diuretics or corticosteroids are susceptible to potassium depletion Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function Hyperglycemia and glycosuria may occur in latent diabetes Chloride deficit and hypochloremic alkalosis may occur Orthostatic hypotension may occur Dilutional hyponatremia may occur in edematous patients in hot weather **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg, edema of cardiac failure—5 to 10 mg, edema of renal disease—5 to 20 mg Dosage adjustment may be necessary during the course of therapy **How Supplied:** Tablets, 2½, 5 and 10 mg

References:

1 Dornfeld L, Kane R Metolazone in essential hypertension The long-term clinical efficacy of a new diuretic *Curr Ther Res* **18**: 527-533. 1975

2 Data on file, Medical Department, Pennwalt Prescription Products

PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
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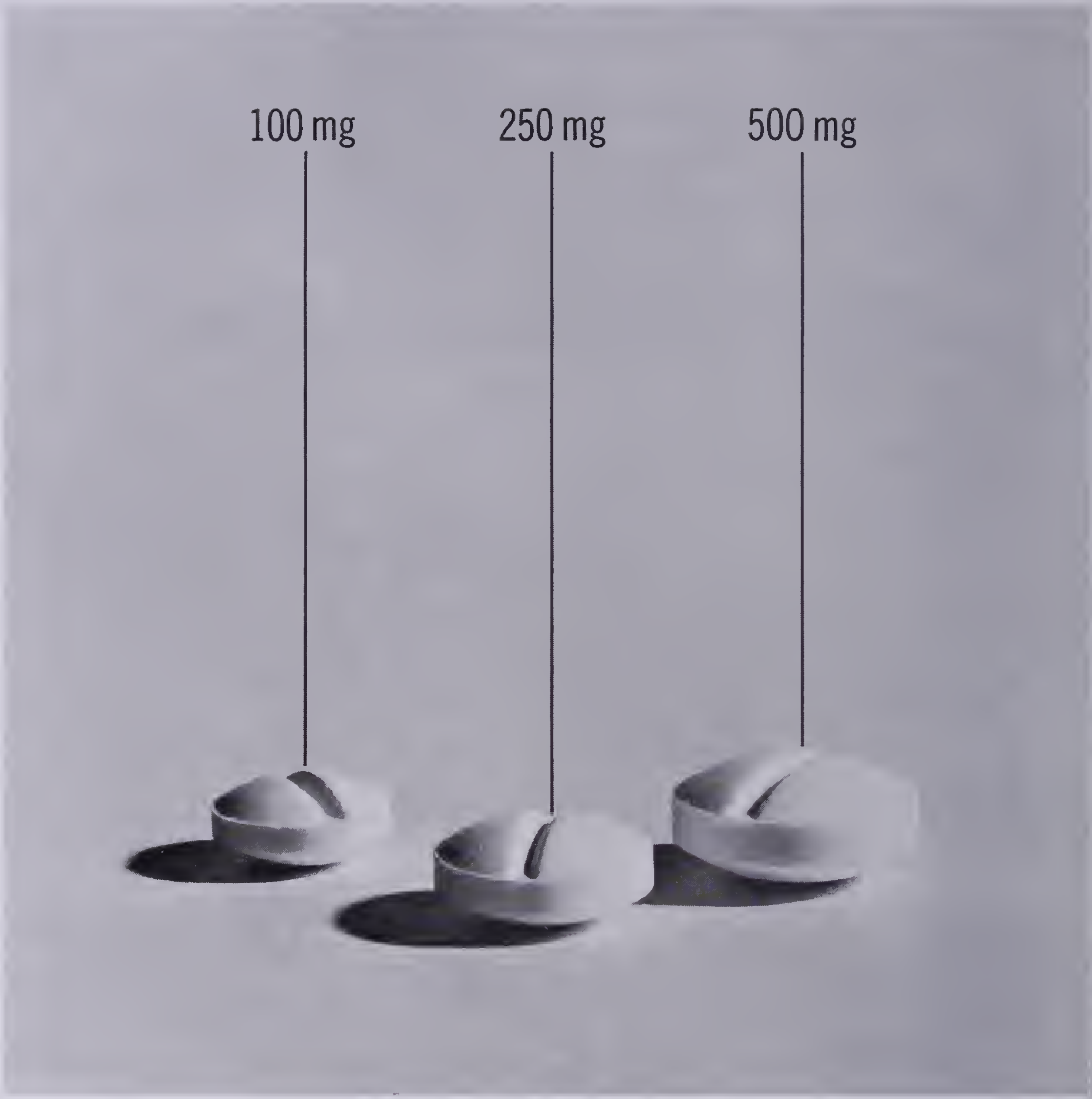
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Category I Courses

Michigan Medicine *each month will carry a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of the new Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing will indicate a contact person, so the physician can obtain details. The list will be expanded as courses are developed by accredited sponsors. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.*

The following have been accredited by MSMS Commission on Continuing Medical Education:

Organizations:

Ann Arbor Psychiatric Association
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Society of Anesthesiologists
University of Michigan School of Public Health

Hospitals:

Alma-Gratiot Community Hospitals, Alma
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med.Center, PC/Little Traverse Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Detroit-Macomb Hospital Association
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Henry Ford Hospital, Detroit
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital), Muskegon
Marquette General Hospital
McLaren General Hospital, Flint
Mercy Hospital, Port Huron
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Oakland Medical Center, Pontiac
Oakwood Hospital, Dearborn
Pontiac General Hospital, Pontiac
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Edward Sparrow Hospital, Lansing
Traverse City State Hospital, Traverse City
V. A. Hospital, Battle Creek
Wayne County Psychiatric Hospital, Eloise
West Shore Hospital, Manistee
Ypsilanti State Hospital, Ypsilanti

Date: April 18-22, Family Practice Review. Location: Towsley Center, U-M Medical Center, Ann Arbor. **Sponsor:** U of M Office of Intramural Education. **Co-Sponsor:** Mich. Academy of Family Physicians. **For:** Family Physicians. **Cost:** $250. **Contact:** U of M Office of Intramural Education*. **Approved for:** 37½ hours of Category I Credit.

Date: April 19-21, Physiology of the Ovary. Location: Scott Hall, WSU School of Medicine. **Sponsor:** WSU Department of Gynecology and Obstetrics. **For:** Obstetricians/Gynecologists, Family physicians. **Cost:** $100. **Contact:** WSU Division of CME**. **Approved for:** 20 hours of Category I Credit.

Date: April 20, Lecture Series in Ophthalmology, "The Pediatric Patient with Nystagmus." Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Ophthalmologists. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 12 hours of Category I Credit.

Date: April 20, Detroit Medical Center Hand Conference, "Peripheral Nerve Injuries: Test for Regeneration, and Evaluation of Sensory and Motor Return". Location: Classroom 3, 2 Webber North, Harper-Grace Hospital, Detroit. **Sponsor:** Harper-Grace Hospital. **For:** Surgeons. **Cost:** No charge. **Contact:** Joseph L. Posch, MD, Fourteenth Floor, Kales Building, 76 W. Adams, Detroit; 48226 (313) 962-9828. **Approved for:** Hour-for-hour Category I credit

Date: April 21-23, Critical Care Symposium, "Monitoring of the Critically Ill." Location: Wayne County Medical Society, 1010 Antietem Road, Detroit. **Sponsor:** WSU School of Medicine. **For:** All interested physicians. **Cost:** $95 physicians in practice; $45 physicians in training. **Contact:** WSU Division of CME**. **Approved for:** 12 hours of Category I Credit.

Date: April 24, 19th Annual Spring Clinic. Location: Valley View Restaurant, Shepherd. **Sponsor:** Gratiot Community Hospital. **Co-sponsor:** Central Michigan Community Hospital. **For:** All specialties. **Cost:** $25. **Contact:** Frank D. Johnson, MD, 1211 South Drive, Mt. Pleasant, 48858. **Approved for:** 8 hours of Category I credit.

DATE: April 26, Serious Infections in Hospitalized Patients; LOCATION: Butterworth Hospital, Grand Rapids; **SPONSOR:** Butterworth Hospital; **FOR:** All interested physicians; **COST:** No charge; **CONTACT:** Erwin J. Haas, MD, 100 Michigan, NE, Grand Rapids, MI 49503; **APPROVED FOR:** 10 hours of Category I Credit

Date: April 26-28, Electrocardiograph Diagnosis. Location: Towsley Center, U of M Medical Center, Ann Arbor. **Sponsor:** U of M Medical School DPM/HPE, Office of Intramural Education. **For:** Family physicians, internists. **Cost:** $180. **Contact:** U of M Office of Intramural Education*. **Approved for:** 23½ hours of Category I Credit.

Colloquium in Maternal-Fetal Medicine

Detroit, Michigan
May 6-7, 1977

The responsibility of obstetricians to prevent perinatal injury is increasing. They must not only know with certainty whether or not fetal growth and development are following patterns of normality, but they are also accountable for delivery of an infant in optimal health.

This two-day Colloquium is designed to provide current information on aspects of maternal-fetal medicine that are of concern and importance to:

- *the practicing obstetrician*
- *obstetrical nursing personnel*
- *physicians engaged in obstetrical training*
- *pediatricians*
- *neonatologists*

Prevention of prematurity, malnutrition, and the detection of antepartum/intrapartum fetal distress will be emphasized as well as the significant parameters of neonatal intensive care, implementation of advanced techniques and application of recently acquired knowledge.

For information and registration, write to:

Federico G. Mariona, M.D.,
FACOG, FACS
Associate Professor,
Dept. Gyn-Ob
Director, Division of Human Parturition
Wayne State University School of Medicine
Hutzel Hospital
4707 St. Antoine Blvd.
Detroit, Michigan 48201

CATEGORY I / *Continued*

Date: April 27, Detroit Medical Center Hand Conference, "Cerebral Palsy in Surgery of the Hand". Location: Classroom 3, 2 Webber North, Harper-Grace Hospital. **Sponsor:** Harper-Grace Hospital. **For:** Surgeons. **Cost:** No charge. **Contact:** Joseph L. Posch, MD, Fourteenth Floor, Kales Building, 76 W. Adams, Detroit, 48226 (313) 962-9828. **Approved for:** Hour-for-hour Category I credit

Date: April 28-29, Program on Hospital Accreditation Standards, Joint Commission on Accreditation of Hospitals. Location: Northville Hilton Inn, Troy. **Sponsor:** Greater Detroit Area Hospital Council. **Co-Sponsor:** Wayne State University. **For:** All Specialties. **COST:** $145. **Contact:** WSU Division of CME**. **Approved for:** 10½ hours of Category I credit

Date: April 29-30, 10th Annual Cancer Symposium. Location: Scott Hall, WSU School of Medicine. **Sponsor:** WSU Department of Oncology. **For:** All interested physicians. **Cost:** $75. **Contact:** WSU Division of CME**. **Approved for:** 14 hours of Category I Credit.

Date: May 4, Recent Advances in Pediatric Surgery. Location: Children's Hospital of Detroit. **Sponsor:** WSU Department of Pediatrics. **For:** Pediatricians, family physicians, surgeons. **Cost:** $35. **Contact:** WSU Division of CME**. **Approved for:** 6¼ hours of Category I Credit.

Date: May 5-6, "Annual Clinic Days," Recent Advances in Pediatrics. Location: Children's Hospital of Detroit. **Sponsor:** WSU Department of Pediatrics. **For:** Pediatricians. **Cost:** $75. **Contact:** WSU Division of CME**. **Approved for:** 12 hours of Category I Credit.

Date: May 5-6, Ophthalmology Conference: Cornea and External Disease. Location: Towsley Center, University of Michigan Medical Center. **Sponsor:** U of M Medical School PGM/HPE. **For:** Ophthalmologists. **Cost:** $140. **Contact:** U of M Office of Intramural Education*. **Approved for:** 14 hours of Category I Credit.

Date: May 11, Common Clinical Problems in Pulmonary Disease. Location: Kalamazoo Hilton Inn. **Sponsor:** Southwestern Michigan Area Health Education Center. **For:** Any interested physicians. **Cost:** $25. **Contact:** Charles Zeller, SMAHEC, (616) 383-6398. **Approved for:** 7 hours of Category I credit.

Date: May 12-13, Pediatric Ophthalmology Symposium. Location: May 12 — Children's Hospital of Michigan and Kresge Eye Institute, May 13 — Michigan Inn, Southfield. **Sponsor;** Children's Hospital of Michigan, and Kresge Eye Institute, Wayne State University. **For:** Ophthalmologists. **Cost:** $120. **Contact:** Gerald T. Davies, MD, ophthalmologist-in-chief, Children's Hospital of Michigan, Detroit Medical Center, 3901 Beaubien Blvd, Detroit, 48201. **Approved for:** 14 hours of Category I credit

Date: May 12-13 — Annual Heart Days. Location: Hyatt Regency Dearborn. **Sponsored by:** Michigan Heart Association. **For:** All interested physicians. **Cost:** $40. **Contact:** Michigan Heart Association, 16310 W. Twelve Mile, PO Box LV-160, Southfield 48076. **Approved for:** 12 hours of Category I credit.

DATE: May 12-13, Medico-Legal Investigation of Death II; LOCATION: WSU McGregor Center; **SPONSOR:** Wayne County Medical Examiner's Office; **CO-SPONSOR:** WSU School of Medicine, Department of Pathology; **FOR:** Pathologists and other interested physicians; **COST:** $60; **CONTACT:** Beaufort Cranford, Department of Conferences and Institutions, Wayne State University 48202; **APPROVED FOR:** 11 hours of Category I Credit

Date: May 16-20, Advances in Internal Medicine. Location: Towsley Center, U of M Medical Center. **Sponsor:** U of M Office of Intramural Education. **For:** Internists. **Cost:** $225. **Contact:** U of M Office of Intramural Education*. **Approved for:** 35 hours of Category I Credit.

Date: May 17, Cancer of the Cervix. Location: Wayne County Medical Society, 1010 Antietam, Detroit. **Sponsor:** WSU Department of Oncology. **Co-sponsor:** Detroit Cancer Club. **For:** All interested physicians. **Cost:** $20. **Contact:** Dorothy Bewley, Dept. of Oncology, Wayne State University, 4160 John R., Detroit 48201. **Approved for:** 2½ hours of Category I Credit.

Date: May 18, Pediatric Dermatology Seminar. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** Pediatricians, family practitioners, dermatologists. **Cost:** $50. **Contact:** Office of CME, St. John Hospital, Detroit, (313) 881-8200, ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: May 25, Multiple Myeloma. Location: Grace Central Hospital. **Sponsor:** WSU School of Medicine. **For:** All interested physicians. **Cost:** $20. **Contact:** Dorothy Bewley, Department of Oncology, Wayne State University, 4160 John R., Detroit 48201. **Approved for:** 2½ hours of Category I Credit.

Date: May 26, Pathology Conference. Location: Towsley Center, U of M Medical Center. **Sponsor:** U of M Office of Intramural Education. **For:** Pathologists. **Cost:** To be determined. **Contact:** U of M Office of Intramural Education*. **Approved for:** 6 hours of Category I Credit.

Date: June 2-3, Blood Banking. Location: Towsley Center, U-M Medical Center. **Sponsor:** Office of Continuing Education, Dept. of PGM/HPE. **Co-sponsor:** American Society for Medical Technology. **Cost:** $75. **Contact:** Office of Continuing Education, Dept. of PGM/HPE, U. of M.*. **Approved for:** 13 hours of Category I credit.

Date: June 7, Continuing Pathology Conference. Location: Towsley Center, U-M Medical Center. **Sponsor:** Office of Continuing Education, Dept. of PGM/HPE. **Cost:** $20. **Contact:** Office of Continuing Education, Dept. of PGM/HPE, U. of Michigan*. **Approved for:** 6 hours of Category 1 credit.

Date: June 8-10, Pulmonary Disease Workshop. Location: Towsley Center, U-M Medical Center. **Sponsor:** Office of Continuing Education, Dept. of PGM/HPE. **Co-sponsor:** M.A.F.P. **Cost:** $180. **Contact:** Office of Continuing Education, Dept. of PGM/HPE, U. of M.*. **Approved for:** 22 hours of Category 1 credit.

Date: June 9-11 — Annual Keyport Trauma Symposium. Location: Otsego Ski Club, Grayling. **Sponsor:** Michigan Committee on Trauma, American College of Surgeons. **For:** All specialties. **Cost:** $25. **Contact:** B. E. Henig, MD, 308 Michigan Ave., Grayling. **Approved for:** 12 hours of Category 1 credit.

Date: June 10 - 12, Workshop on Human Sexuality for Physicians and Health Care Professionals. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital Department of Psychiatry. **For:** Physicians, Psychologists, Social Workers and other Health Care Professionals. **COST:** $125. **Contact:** Norman Rosenzweig, MD, (313) 272-6000, Ext. 8516. **Approved for:** 22 Hours of Category 1 Credit.

Date: June 15-24, Advanced Institute in Methods of Immunological Diagnosis. Location: Cranbrook Educational Community, Bloomfield Hills. **Sponsor:** Wayne State University School of Medicine. **For:** All interested physicians. **Cost:** $600. **Contact:** Noel R. Rose, MD, PhD, Department of Immunology and Microbiology, WSU, 540 East Canfield, Detroit 48201. **Approved for:** 60 hours of Category 1 credit.

Date: June 20-24, Northern Michigan Summer Conference. Location: Shanty Creek Lodge, Bellaire. **Sponsor:** Office of Continuing Education, Dept. of PGM/HPE. **Cost:** $200. **Contact:** Office of Continuing Education, Dept. of PGM/HPE, U. of M.*. **Approved for:** 22 hours of Category 1 credit.

Date: June 22, Carcinoma of the Thyroid. Location: Grace Central Hospital, Detroit. **Sponsor:** WSU School of Medicine, Dept. of Oncology. **For:** All interested physicians. **Cost:** $20. **Contact:** Dorothy Bewley, (313-494-6025), 4160 John R, Detroit, Mi 48201. **Approved for:** 2½ hours of Category 1 Credit.

Date: Monthly, Ob/Gyn Journal Club. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** All interested physicians. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category 1 Credit.

Date: Monthly Urology Journal Club; Location: Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Urologists; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital****; **Approved for:** 2 hours of Category 1 Credit.

Date: Continuing Quarterly Journal Club — Surgery; Location: Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Surgeons, **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Monthly, Cleft Palate Clinic. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital****. **For:** Oral Surgeons, plastic surgeons, pediatricians. **Cost:** None. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 3 hours of Category 1 Credit.

Date: Monthly, Tissue Audit (Cancer). Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Surgeons, ob-gyns, pathology, radiology. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 2 hours per session Category 1 Credit.

Date: Monthly Lecture Series in Ophthalmology; Location: Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Ophthalmogists; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital**** **Approved for:** 2 hours of Category 1 Credit.

Date: Every Tuesday — Psychiatry — Special Problems Seminar; Location: Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Psychiatrists; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital****; **Approved for:** 2 hours of Category I Credit.

Date: Every Tuesday morning, Gynecology/Obstetrics Combined Grand Rounds. Location: Jackson Auditorium, Hutzel Hospital. **Sponsor:** Wayne State University Department of Gynecology-Obstetrics. **For:** All interested physicians. **Cost:** No charge. **Contact:** Wayne State University, Division of CME**. **Approved for:** 4 hours each of Category 1 Credit.

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Robert M. Zimmerman, M.D.

PR activities were advanced at the recent meeting of the MSMS Committee on Public Relations, chaired by Thomas C. Payne, MD, second from left, of Lansing. Visiting in the MSMS lobby are, left to right, H. Ross Hume, MD, Petoskey; Doctor Payne; a PA student from Mercy College; and Archie Bedell, MD, chairman of the Wayne County Medical Society PR Committee.

Ways that the Auxiliary, Medical Assistants and component societies can assist MSMS public information projects are discussed by, left to right, Nelda Gasperson, executive secretary, Macomb County Medical Society; Joan Salinas, Michigan medical assistants society; Sally Schiel, executive secretary, Washtenaw County Medical Society, and Mrs. Ruth Dixon, president, MSMS Auxiliary.

CATEGORY I/*Continued*

Date: Each Wednesday, Detroit Medical Center Hand Conference. Location: Classroom 3, Second Floor, Webber Wing, Harper Hospital, Detroit. **Sponsor:** Wayne State University. **For:** Surgeons. **Cost:** No charge. **Contact:** Joseph L. Posch, MD, Fourteenth Floor, Kales Building, 76 W. Adams, Detroit 48226. **Approved for:** Hour-for-hour Category I credit.

Date: Second Thursday of each month, Inter-Hospital Pathology Slide Conference. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** Pathologists. **Cost:** No charge. **Contact:** Department of CME, St. John Hospital, 22101 Moross Road, Detroit, 48236, (313) 881-8200. **Approved for:** 3 hrs. each date Category I Credit.

Date: Saturdays, Morbidity and Mortality Conference. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital Department of Surgery. **For:** Surgeons. **Cost:** None. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 2 hours of Category I Credit per session.

Date: Every Saturday, Weekly Conference. Location: Gamble Building, Burns Clinic/Little Traverse Hospital, Petoskey. **Sponsor:** Burns Clinic/Little Traverse Hospital. **For:** All interested physicians. **Cost:** None. **Contact:** Ernest W. Carpenter, MD, 560 West Mitchell, Petoskey, 49770.

Date: Begins September, 1976, Continuing Training in Family Therapy. Location: Suite 1212, North Park Plaza, 17117 W. Nine Mile Road, Southfield. **Sponsor:** Family Institute of Southeastern Michigan. **Co-sponsor:** Ackerman Institute. **For:** Psychotherapists. **Cost:** Varies according to time put in. **Contact:** Carolyn R. Tourkow, MSW, director, Family Institute of Southeastern Michigan. **Approved for:** Hours vary with time spent.

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*Office of Intramural Education, University of Michigan Medical Center, Dep't. of PGM/HPE, Ann Arbor, 48109

**WSU Division of CME, Room 1209, Scott Hall, 540 E. Canfield, Detroit, 48201 (313) 577-1453

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing. 48902

****Department of CME, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 272-6000

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The following article is the first in a series. The articles, written especially for *Michigan Medicine* by Lansing free-lancer Gene Hashley, will profile Michigan legislators who are key figures in the formulation of health care legislation and programs.

Ray Kehres

Ray Kehres' priority – less expensive health care

Back when Ray Kehres was an industrial welder, the only health care he worried about was that needed by himself or his family. But things have changed.

Now State Rep. Raymond C. Kehres of Monroe is a recognized legislative leader in the health care and social services area.

Kehres spent four years on the Michigan House Public Health Committee. He then was appointed to the House Appropriations Committee and now is chairman of the Appropriations Sub-Committee on Social Services. He thus deals with state financing of public health services, including Medicaid. And he maintains his interest in the quality of health care service for Michigan residents.

Kehres is well informed about public health issues and projects genuine and sincere concern for the health and welfare of Michigan residents.

During sessions of the House, Kehres is not one to jump to the microphone on every issue. He plays an important role in floor debate only on issues that involve his constituency and his areas of specialty — public health, social services and appropriations.

"I'm interested in people," he says. "I want to see that their needs are

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met at the least possible cost to the taxpayers of the State of Michigan."

Top health issue

He views the number one issue in the health care area as progress toward less expensive levels of health care services.

"I'd like to see us move away from the most costly forms of health care such as hospital confinement. There are people in hospitals who don't need such an extensive kind of nursing care.

"For the past 15 years or so we've been over-bedding our hospitals. Perhaps we could have fewer hospitals if we placed more emphasis on home and outpatient care."

Kehres also would like to see more emphasis placed on developing resources for preventive medicine. "Educating people to practice better personal health care, I believe, could go a long way toward cutting medical care costs," he says.

"If we could pay the dollars, and I'm talking Medicaid now, that we should be paying for office calls, there would be more people in the offices.

"Or, instead of visiting people in the hospitals, doctors could go to the homes. Doctors say it would be cheaper to keep the patient in the home and pay $35 or $40 for a house call than it would be to keep them in the hospital at $200 a day," he says.

Health care regulation

Kehres says he feels there needs to be good regulation of health care providers to give the public confidence.

"If there are complaints, we can't have them covered up or not acted upon. I think that's where the public has been shortchanged in the past.

"The regulatory boards are composed of members of the profession and have, or at least the public believes they have, a tendency to protect themselves. I think it is vital that we get some public members on the boards and I think we need to have very prompt action on complaints. If complaints are not looked at by the boards there needs to be another safety valve where someone does take care of them.

"I don't say that we must take regulation completely out of the hands of the professions, but there has to be some way to make sure the public is taken care of," Kehres said.

On continuing education, Kehres said he feels Michigan took a major step forward in the last couple of years in requiring 50 hours annually of continuing education for physicians.

"We should give more publicity to that and let the public know that our doctors are continuing to upgrade themselves. I think it is a big move in the right direction and I'd like to keep it up."

On the Medicaid issue, Kehres says there is a need for the legislature to pursue any cost containment measure in order to carry out the goal of bringing good health care to the poor.

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By Mert Scholten
MSMS Communications Department

Donald G. Albert, MD, Troy, is new plant medical director of Fisher Body Division's Central Engineering Activity. Doctor Albert also is an assistant professor of medicine at WSU and a senior attending physician at Beaumont Hospital.

Benjamin B. Blum, MD, Petoskey, was honored recently by the Petoskey-Harbor Springs Chambers of Commerce for his long service to the two communities. A plaque presented to Doctor Blum at the annual regional Chamber of Commerce dinner reads: "To B. B. Blum, MD, who has devoted his life to the community to make it a better and more healthy place to live."

James W. Burdick, Southfield attorney and Paul T. Lahti, MD, Royal Oak general surgeon and MSMS Councilor, have been appointed to the Michigan Medical Practice Board by Gov. Milliken. Mr. Burdick is designated a "public member" of the board for a term ending September, 1979 while Doctor Lahti is filling out a term which expires in September of this year.

Robert B. Carbeck, MD, Ann Arbor, has been invited to serve on the Graduate Medical Education National Advisory Committee of the Health Resources Administration of HEW. The appointment runs until late 1979.

Dean C. Elliott, MD, Sanders A. Frye, MD and Jean H. Webster, MD, Petoskey, were honored recently during the Burns Clinic annual awards banquet for 20 years of service to the Petoskey area.

Tommy Evans, MD, Detroit, president, American College of Obstetrics and Gynecology, and **Warren F. Tryloff,** director, Michigan State Medical Society, have been appointed to the advisory panel and as a consultant, respectively, of the international "Advances in Medicine" Conference to be held in London, England, July 23-28, 1978. The Royal Society of Medicine and the British Medical Association are among the sponsors of the prestigious event which will have as its theme the medical ages of man.

William R. Mann, DDS, Ann Arbor, dean, The University of Michigan School of Dentistry, is new president of the Michigan Health Council. **Roland G. Hiss, MD, Ann Arbor,** is a new trustee and will serve a three-year term.

Robert J. Mason, MD, MSMS past president, formerly of Birmingham, writes that he practices about three days a week as a pediatric consultant at the Eastern Shore Hospital Center, Cambridge, MD, and also serves the Geriatric Evaluation Service at the local health department. He is also active as the public education officer for the Coast Guard Auxiliary Flotilla and is secretary of the Oxford Sailing Association. The address for Doctor and Mrs. Mason is PO Box 266, Oxford, Md. 21654.

Theodore Meadows, MD, Ann Arbor, was honored recently by the Washtenaw County Section of the National Council of Negro Women for his community service and contributions to the Black community. Doctor Meadows, a pathologist at St. Joseph Mercy Hospital, serves as president of the Ann Arbor Housing Commission, member of the Community Development and Revenue Sharing Committee, and chairman of the planning committee of the Community Advisory Board of St. Joseph Mercy Hospital.

Jack Ryan, MD, Sterling Heights, is new president of the Detroit-Macomb Hospitals Association. Doctor Ryan has been a member of the association's board of trustees for 11 years and has been chief of staff for six years.

John Spencer, MD, Traverse City, has been reappointed to a term on the Great Lakes Fishery Advisory Committee by Governor Milliken.

Alfred B. Swanson, MD, Grand Rapids, is new Vice-President of the American Society for Surgery of the Hand. Doctor Swanson and his wife, **Genevieve Swanson, MD,** a plastic surgeon, were featured guests on ABC-TV's "Good Morning, America" show in New York in mid-January shortly after he had been a guest speaker at the Academy of Medicine in Toronto.

Thomas Watkins, MD, Alpena, recently received the "Silver Beaver Award," the highest honor bestowed on volunteer Scouters. Doctor Watkins has given nine years of service to scouting as district finance chairman, district chairman, executive board member and, most recently, council vice-president. Doctor Watkins also is current president of the medical staff and chief of the nursery at Alpena Hospital.

Michigan authors include **J. W. Hysell, MD, and J. M. Gray, MD, Ann Arbor,** who published "Thrombocytopenic Purpura Following Iopanic Acid Ingestion" in the Jan. 24, 1977 issue of the *Journal of the American Medical Association (JAMA)* . . . **D. A. Sargent, MD, V. W. Jensen, MD, T. A. Petty, MD and H. Raskin, MD, Detroit,** were collaborating authors of "Preventing Physician Suicide" which was a featured in the Special Communication Section of the Jan. 10, 1977 issue of *JAMA* . . . **John Dorsey, MD, Detroit,** is the author of a book published in late 1976 entitled *An American Psychiatrist in Vienna, 1935-1937 and his Sigmund Freud.* Published by the Center for Health Education, the book is the latest in a highly personalized, autobiographical series of books and other writings.

"Every doctor of medicine licensed to practice medicine or surgery within this state shall...apply to the state medical board for a certificate of triennial registration.... The applicant shall include satisfactory evidence to the board that in the preceding three years the practitioner had completed 150 hours of continuing medical education..."

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In Memoriam

Enrique D. Covani, MD
Pontiac

Enrique D. Covani, MD, Pontiac Township, died Feb. 20 at the age of 44. Doctor Covani graduated from the Universidad Nacional del Litoral in Argentina and served since as an obstetrician-gynecologist at Pontiac General Hospital. He was diplomate of the American Board of Obstetrics and Gynecology. He also was a fellow of the American College of Obstetrics and Gynecology.

Cuthbert E. DeMay, MD
Jackson

Cuthbert E. DeMay, MD, Jackson, who served as a medical doctor for 57 years, died Jan. 27 at the age of 82. A graduate of the Wayne State University School of Medicine, he began his practice in Jackson in 1916, served as an Army doctor during World War I, was a member of the first staff of Mercy Hospital, now Foote Hospital West, and served as chief of staff.

Ira G. Downer, MD
Grosse Pointe Park

Ira G. Downer, MD, Grosse Pointe Park, died Feb. 28 at the age of 84. Doctor Downer was the first chief of surgery for Bon Secours Hospital, Grosse Pointe. A graduate of the Wayne State University School of Medicine, he also founded Detroit's Riverside Clinic. Doctor Downer was past chairman of the MSMS surgical section, and a charter member and past president of the Detroit Academy of Surgery.

Louis P. Groos, MD
Escanaba

A general practitioner for 54 years, Louis P. Groos, MD, died Feb. 16 at the age of 82. He began his practice in Escanaba in 1922, joining his father, John Groos, MD, and later his brother, the late Harold Groos, MD. Doctor Groos received his medical degree in 1919 from the University of Illinois and was affiliated with St. Francis Hospital in Escanaba. He served as president of the Delta County Medical Society and was twice head of the Upper Peninsula Medical Society. He was awarded a 50-year pin in 1971 by MSMS.

Thomas J. Jamieson, MD
Detroit

Thomas J. Jamieson, MD, 81, died Jan. 18. Doctor Jamieson graduated from the University of Toronto in 1926, and was affiliated with Wyandotte, Oakwood and Peoples Community hospitals. He was a general practitioner with special attention to internal medicine.

Nathan J. Kapetansky, MD
Southfield

Nathan J. Kapetansky, MD, Southfield, died Jan. 13 at the age of 74. Doctor Kapetansky graduated from Wayne State University School of Medicine in 1928 and was affiliated with Brent and Detroit general hospitals of Detroit. He was a member of the American Academy of General Practice.

Edmund J. Knobloch, MD
Fair Haven

Edmund J. Knobloch, MD, 81, of Fair Haven, died Feb. 13. A graduate of the Wayne State University School of Medicine, Doctor Knobloch served as Wayne County Medical Examiner for 25 years. He was affiliated with St. Francis Hospital, Hamtramck, and served in the First World War.

Harriet E. McLane, MD
Detroit

Harriet E. McLane, MD, 89, who in 1917 became the first woman doctor employed by the Detroit Board of Health, died Feb. 8. After graduating from the Women's School of Medicine in Philadelphia, the psychiatrist moved to Detroit and served for many years on the staffs of Hutzel and Harper hospitals as well as the Metropolitan Child Guidance Clinic. Doctor McLane was a member of the American Psychiatric Association.

Herbert B. McLauthlin, MD
Jackson

Herbert B. McLauthlin, MD, 61, died Feb. 20. Doctor McLauthlin, of Jackson, was former chief of anesthesiology at Mercy Hospital and chief of staff at Foote Hospital West. A graduate of the University of Colorado School of Medicine, he served as a military doctor in England during World War II. He was a member of the Michigan and American societies of anesthesiologists.

Hugh K. Moir, MD
Battle Creek

Hugh K. Moir, MD, Battle Creek, died Jan. 24 at the age of 76. He was a graduate of the University of Toronto Faculty of Medicine and was a member of the American Psychiatric Association.

Ralph H. Pino, MD
Farmington Hills

Ralph H. Pino, MD, ophthalmologist, died Feb. 17 at the age of 88. Doctor Pino, of Farmington Hills, graduated from the University of Illinois Medical School and was a former chief of the department of ophthalmology at Harper Hospital in Detroit, as well as medical director of sight-saving and braille in the Detroit public schools for 20 years. He was past president of both the Wayne County Medical Society and the Detroit Ophthalmological Society, former MSMS delegate and professor emeritus of ophthalmology at Wayne State University's School of Medicine. He was a fellow of the American College of Surgeons, a licentiate of the American Board of Ophthalmology, and member of the American Academy of Ophthalmology and Otolaryngology.

Rigdon K. Ratliff, MD
Ann Arbor

Long-time Washtenaw County urologist Rigdon K. Ratliff, MD, died

Jan. 29 at the age of 75. Doctor Ratliff, former chief of staff at St. Joseph Mercy Hospital, Ann Arbor, graduated from the University of Michigan Medical School. He organized and headed the hospital's research program and also founded the St. Joseph Mercy Hospital laboratory. Former president of the Reed M. Nesbit Urological Society and the Detroit Branch of the American Urological Association, Doctor Ratliff was also former secretary of the Washtenaw County Medical Society. He belonged to the American Urological Association and The American College of Surgeons.

Russell F. Salot, MD
Mt. Clemens

Russell F. Salot, MD, Macomb County surgeon, died March 1 at the age of 75. A graduate of Wayne State University School of Medicine, he was past president of Macomb County Medical Society. He was a captain in the medical corps of the USNR.

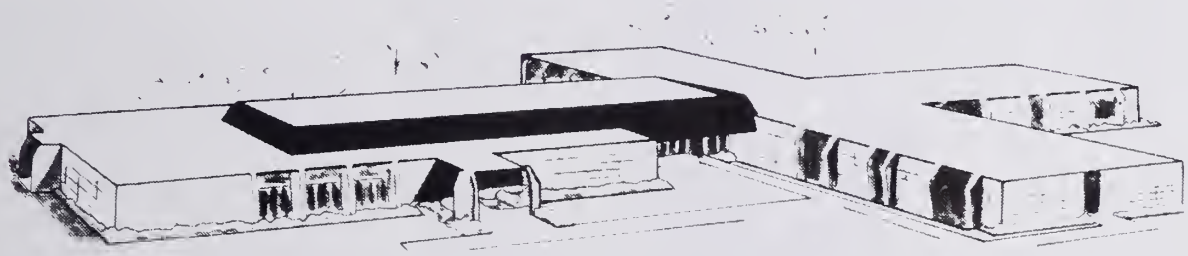
Myer Teitelbaum, MD
Southfield

Myer Teitelbaum, MD, Southfield internist, died Feb. 21 at the age of 67. Doctor Teitelbaum was a graduate of the University of Michigan Medical School, where he later taught, and was on staff at Grace and Sinai hospitals in Detroit. He had also served as an assistant adjunct professor of clinical medicine at the Wayne State University School of Medicine. He was a member of the American Diabetes Association and the American Society of Internal Medicine. He was a fellow of the American College of Physicians.

Maurice B. Wehr, MD
Taylor

Maurice Burton Wehr, MD, Taylor, died at the age of 54 Jan. 14. An ophthalmologist, Doctor Wehr graduated from George Washington Medical School, Washington D.C. He was a member of the American Academy of Ophthalmology and Otolaryngology and the Association for Research in Ophthalmology, Inc. He also served in the U.S. Navy.

FOREST VIEW PSYCHIATRIC HOSPITAL



Jack N. Carr, MD, Medical Director

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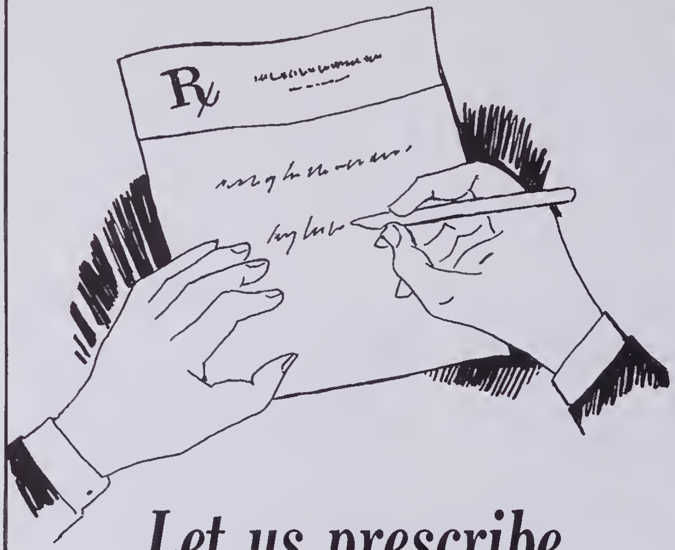

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California Assemblyman Barry Keene, left, visited Lansing in February to describe his experience in gaining passage of the California Natural Death Act. He met with, from left, Thomas R. Berglund, MD, Kalamazoo, chairman, MSMS Committee on State Legislation; Rep. David Hollister (D-Lansing), and Joseph Kincaid, MD, Kalamazoo.

Tips for drug control by Michigan Physicians

In a recent meeting with members of the MSMS Committee on Alcohol Abuse and Drug Dependency, William G. Streiff, regional compliance chief of the Drug Enforcement Administration asked that physicians be reminded of several actions that would make his job much easier. The committee passes on the following tips for better drug control:

- Prescription pads should never be left where they can be stolen.
- Physicians' identification numbers should not be printed on their prescription blanks.
- In writing prescriptions, the amounts of pills should be written out as well as stated in numbers, as one would write out a check, viz: "Dispense 20 (twenty) tablets," in order to prevent addicts from adding another zero.
- Physicians' assistants and nurses are not licensed to prescribe drugs. To permit them to do so is a violation of the law.
- Amphetamines and other weight control drugs are only effective in reducing appetite for about 21 days. Their use after that period of time produces dependency but does not aid in appetite control.

Mr. Streiff is concerned about the increasing use of phendimetrazine (Bacarate, Bontril, Melfiat, Obe-Nil, Plegine, Statobex, Trimstat, Trimtabs). Physicians should be particularly careful about dispensing large quantities of these drug preparations for fear they may be sold on the street.

New AMA drug publication ready

The third edition of AMA Drug Evaluations, the American Medical Association's compendium of information about drugs for the physician, will be off the press this spring, the AMA announced today.

The third edition has been completely revised, updated and expanded. It contains more than 1,300 pages of essential data for today's drug-prescribing or dispensing physician. It evaluates most available drugs and compounds and recommends dosage ranges. Included are generic and proprietary names, structural formulas, indications, contraindications and adverse reactions.

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(That message was timely when it appeared in the MSMS Journal in 1925 – 50 years ago – and it is equally timely now – the Editor.)

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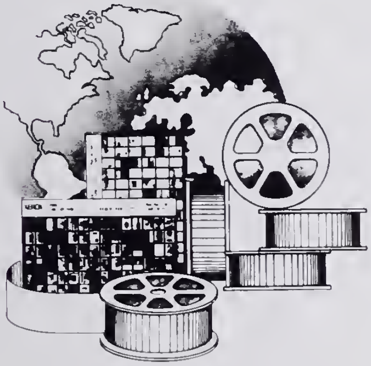
PHYSICIAN ASSISTANT — Graduating August, 1977, from WMU with BS in medicine, seeking employment with FP, GP or surgeon, preferably in West Central area. Curriculum vitae available upon request. Please contact A. P. Giannelli, 9605 East D Ave., Apt. 11, Richland, MI 49083 (616) 629-4008.

Presidents of the Wayne, Oakland and Macomb county medical societies met with MSMS Council Chairman Ernest P. Griffin, Jr., MD, second from left, at the installation of WCMS President Arthur Ulmer, MD, left. Second from right is Edward S. Maxim, MD, MCMS president, while OCMS President John B. Bryan, MD, is at right.

This Publication....



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Potpourri

By Herbert A. Auer, Executive Editor

HOW WOULD YOU identify middle income people? Former President Ford described the middle as ranging from $8,000 to $30,000; Financial writer Lee Smith puts the middle rate at $20,000 to $99,000. Statistics show only 25 percent of American families make more than $20,000, only 14 percent make more than $25,000 and only 1.4 percent make $50,000 or more.

BACK IN 1925, MSMS was encouraging each component medical society to "have a group of two or three members who will prepare a program and give it on request before at least three other component societies." An article in the *MSMS Journal* for November 1925 reported that "scientific teams are going from one county society to a neighbor society." This visitation idea was one of a five-point minimum program for components — the other points suggested 10 scientific meetings every year, at least three dinner meetings, five lectures each year to high schools and civic groups and a working publicity committee.

WATCH FOR A REPORT soon from the blue-ribbon national commission appointed by the AMA to put the causes of rising medical costs in proper perspective. "The objective is to see that costs are acted upon in the light of reason rather than the heat of politics," says Richard E. Palmer, MD, AMA president.

A RECENT GOVERNMENT survey shows that it costs Social Security $12.39 to process every Medicare claim, but private carriers process claims for $6.45. Meanwhile, newspaper headlines continue to blame doctors for the high costs of the Medicare program.

IT HAPPENED. MSMS received a letter the other day addressed to Doctor William Beaumont asking for illustrated booklets about the digestive process. The letter was sent by an eighth grader from Baxley, Georgia. We wonder where he got Doctor Beaumont's address?

TRUE OR FALSE? A physician from Michigan has never been president of the AMA? The answer is "false," but it has been many years since Victor C. Vaughan, MD, then dean of the University of Michigan Medical School, was the 1914 president of the AMA. Doctor Zina Pitcher, once mayor of Detroit, was 10th president of the AMA in 1856. William Brodie, MD, president of the Wayne County Medical Society for 12 years and president of MSMS in 1876, was the AMA president in 1886. Donald MacLean, MD, who practiced in Ann Arbor and Detroit, was the AMA president in 1895.

PHARMACEUTICAL COMPANIES CURRENTLY are spending $1.2 billion a year on research — two and one-half times as much as in 1967. Yet fewer drugs are being introduced. The investment cost per new chemical entity is almost twice what it used to be.

DOCTORS ARE ENTITLED to preach more about non-smoking. The Surgeon General reports that 42.4 percent of all males over 21 smoked in 1964 but the figure was down in 1976 to 39.3., Physicians as a group were well below that figure with the greatest reduction of all segments.

SOME TEACHERS AND ATTORNEYS and their families "seem to be quite reluctant to sign arbitration forms," writes Edward B. Feehan, MD, Chairman, Legislation-Arbitration Committee, Merced-Mariposa Medical Society in California, in the *Western Journal of Medicine*. He adds that he does have a generous sprinkling of both groups that do go ahead and sign. He writes that in his own office, "I tend to decline to accept nonemergency cases where the patient is a new patient and reluctant to sign."

THE WARNING WAS issued, "Government is calling more of the shots because it is buying more medical care," at the AMA Congress on Medical Education by Charles A. LeMaistre, MD, chancellor, University of Texas System.

IN COMMENTING ABOUT the upcoming debate in Congress about NHI, Wayne County Medical Society President Arthur A. Ulmer, MD, said in his inaugural address, "It is organized medicine's responsibility to provide leadership, not only to its members, but to the nation at this time. No longer can there be opposition without presenting viable alternatives, and no longer can decisions be based on desire or expediency."

SEVENTY-FIVE PERCENT of the doctors in an American Academy of Pediatrics survey said they would take on new Medicaid patients. The survey found the average pediatrician works 60 hours a week and makes $15.80 an hour.

THE EDITORS OF THE *New England Journal of Medicine* complain in their "Notice to Authors" that they are tired of struggling with sentences like: "In recent years there has been a great deal of interest in studies of significant enzymatic parameters carried out in tail-less mice utilizing methods that hopefully explain the absence of tails."

Michigan Medicine Contents

***Michigan Medicine*, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about contemporary issues and actions of the Michigan State Medical Society, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.**

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The Publication Committee of the MSMS Council is the editorial board of *Michigan Medicine* and advises the Council and the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

In the next issue . . .

MSMS malpractice claims report.

President's Page

Physicians need help of others to be free and independent

Vernon V. Bass, MD
MSMS President

So . . .

You like being a physician, a member of the learned profession — man's relationship to nature.

You like being a professional — the best performance of the task being paramount.

You like being free and independent, and happy. Indeed, you must be! But you need the help of others.

Organizations are created by mankind to perform the tasks that you with an individual brain and two hands cannot do. The institutions that guard man's health, extend his knowledge and minister his religious needs are the organizations by which man achieves most of his necessary and noble purposes. These are the organizations upon which modern civilization rests.

You need your county medical society locally, MSMS on the state level, and the AMA nationally to stir the alphabet soup of PSRO, HSA, FDA, HEW, JCHA, NHS, FTC, NHI, CME, etc.

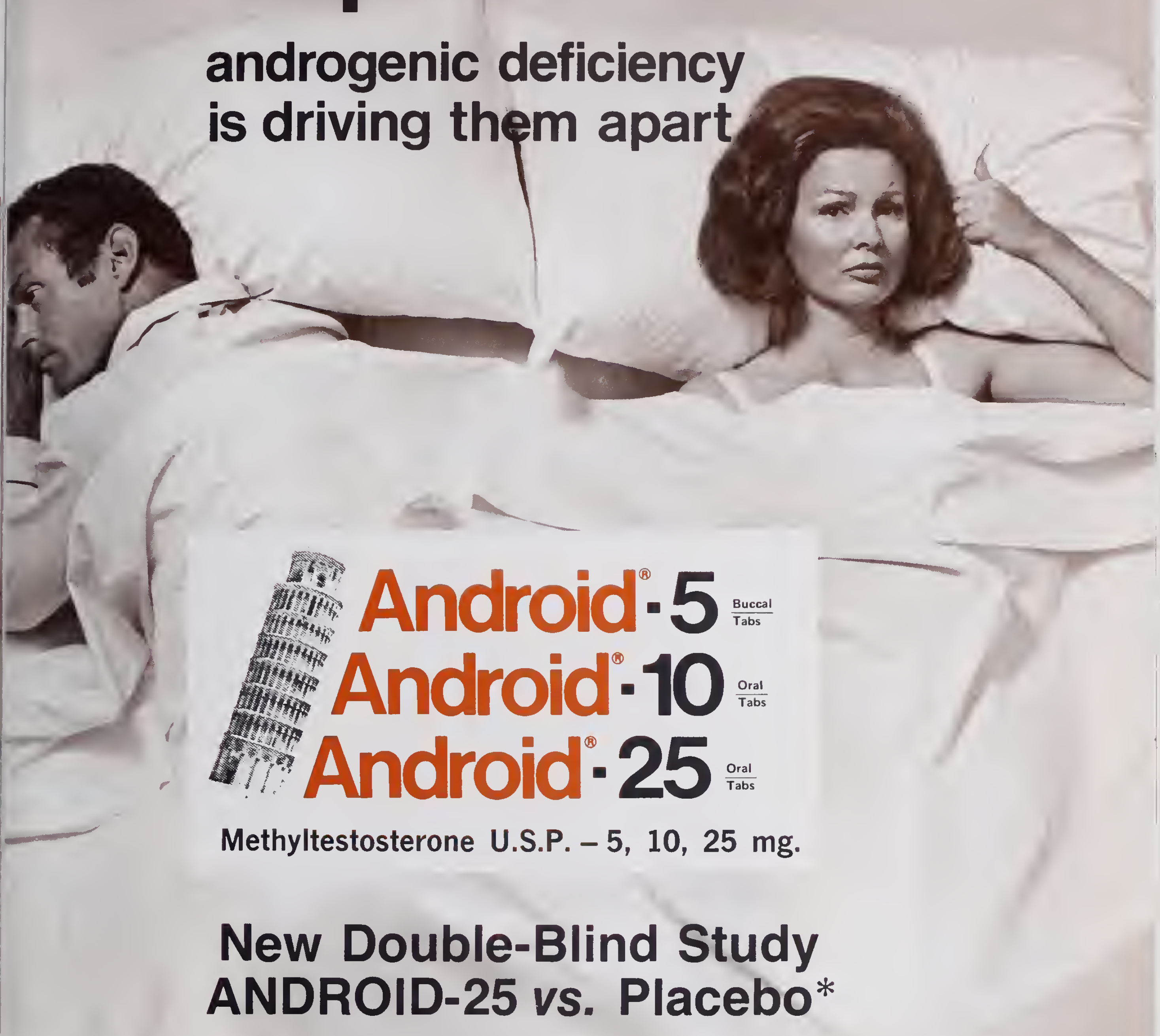
You must be heard at all levels and you must voice your opinions solidly. You, a minority, must think, talk, bargain, and when a decision is reached, close ranks in a guild-type unity to present a solid front to convince the majority.

As president of MSMS, I will be your voice and servant, even as I was the House of Delegate's voice and servant for six busy, productive, tumultous, and happy years.

I'm grateful for this high honor and the opportunity to be of service. I approach the task with some anxiety and great humility. Certainly, I would despair were it not for the resources of wisdom, virtue, and zeal reposing in our MSMS staff, the Council, the House of Delegates, and the membership of MSMS.

You must continue to help with your prayers and intelligence. And with your help, I look forward to the challenge.

When **impotence** due to androgenic deficiency is driving them apart



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WRITE FOR REPRINT: R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; + + = 50% improvement; + + + = 75% improvement. Placebo effectiveness was + or + + in 12.7% of trials. Android-25 elicited a +, + + or + + + response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg., Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg., Postpuberal cryptorchism, 30 mg **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974 **HOW SUPPLIED:** 5, 10, 25 mg in bottles of 60, 250. Rx only

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Support malpractice bills; call, visit your legislator

By Thomas R. Berglund, MD
Chairman, MSMS Committee on State Legislation

A great opportunity to "do something about malpractice" now is available to Michigan physicians.

Three bills which could mean a lot to alleviate malpractice insurance woes of Michigan doctors have been introduced in the Michigan legislature. The bills currently are in the House Judiciary Committee, awaiting hearings and reporting for the next step in the legislative process.

The MSMS Council urges MSMS members to contact their own legislators to lobby for hearings and reporting out of the bills.

Foremost among the bills is HB 4515. Introduced by Rep. E. Dan Stevens at MSMS' request, it presents a statutory definition of medical malpractice and places the burden of proof on the plaintiff. Co-sponsors with Rep. Stevens are Reps. Cushingberry, Campbell, Evans, Busch and Angel.

HB 4215 establishes a $500,000 ceiling on malpractice insurance verdicts and prescribes a priority for allocation of funds over $50,000. HB 4215 is sponsored by Rep. Bryant.

HB 4263 provides that when a plaintiff loses a malpractice case by dismissal or by a jury verdict of no cause, the plaintiff shall reimburse the defendant for fees and expenses determined by the court to be legitimate costs of defense. HB 4263 is sponsored by Rep. Nash.

(Another bill of note is SB 15, one of many bills for each health profession, aimed at denying licensure after proving Medicaid fraud.)

The brief definition of malpractice in HB 4515 states, "In an action alleging malpractice the plaintiff shall have the burden of proving by affirmative evidence that: (1) The defendant failed to provide the plaintiff the recognized standard of accreditable professional practice in the profession or the specialty of the profession in the community in which the defendant practices or in a similar community (and) (2) as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury which would not otherwise have occurred."

Each of these bills has been supported by the MSMS Council at the recommendation of the MSMS Committee on State Legislation and Regulations.

Physicians wishing further information may contact Bruce Ambrose, manager, MSMS Department of Government Relations.

Program – 1977 Gull Lake Meeting

MSMS Committee
on Maternal and Perinatal
Health

and

Great Lakes/Great Plains
Maternal Mortality
Study Group

May 25-28

Gull Lake Conference
Center
Hickory Corners

Thursday, May 26

8 a.m. Meeting, MSMS Subcommittee on Obstetrical and Neonatal Planning

10 a.m. Meeting, MSMS Committee on Maternal and Perinatal Health

1:15 p.m. Program, "Home Deliveries — Passing Fad or Here to Stay?" Lloyd A. Kammeraad, MD, Grand Rapids, Chairman

7:30 p.m. Program, "PBB/PCP Teratological and Pediatric Aspects," Mason Barr, MD, associate professor of pediatrics and director, Teratology Unit, University of Michigan

Friday, May 27

8 a.m.-noon
- Placental Tissue Registry Report
- Maternal Mortality Tissue Registry
- Maternal Deaths in Teenagers
- Minnesota Maternal Mortality Study
- Maternal Mortality in the State of Nebraska
- Pass the Word — the Wisconsin experience

1:30 p.m. Session, Great Plains/Great Lakes Maternal Mortality Study Group

Saturday, May 28

8 a.m. Wrap -up, Great Plains/Great Lakes Maternal Mortality Study Group

The meeting is open to all interested Michigan physicians. Reservations must be made in advance, while all fees are payable at the meeting.

Reservations and information may be obtained from Helen Schulte at MSMS headquarters.

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"What good is . . . arbitration if the patients refuse?"

While I am in favor of all the physicians, of course, participating in the medical malpractice arbitration program, I wonder about the reverse side of the coin.

I am at the hospital each and every day and most notable is the fact that the great majority of patients in the emergency room, in the clinic, and patients being admitted to the hospital, refuse to sign the permit for arbitration.

What good is it if the physicians agree to arbitration if the patients refuse?

What point is there in making a law that states that 90% of the physicians in any one hospital, etc., must participate in such an agreement, if 90% of the patients refuse?

What is the cut-off point in this regard?

Surely this must be a matter of concern for people who propose arbitration in the event that most patients refuse to accept arbitration.

Richard S. McCaughey, MD
Royal Oak

". . . would like to see a copy."

Please send me a recent issue of your journal MICHIGAN MEDICINE. I read about the new approach you are taking with it in the RAGAN REPORT and would like very much to see a copy.

Thank you,

Lynn Johnson
IC System, Inc.
St. Paul, Minn.

(Editor's note: Persons across the country are requesting copies of Michigan Medicine *following a note in the national newsletter,* Ragan Report, *about the news/issue oriented MSMS journal.)*

"I would like . . . a complete set of . . . reference cards . . ."

In a recently published edition of *Michigan Medicine,* the "Maternal Health Desk Reference Card #4 (revised 9/19/74)" caught my eye. Having reviewed it and being impressed by its usefulness and conciseness, I would like to request a complete set of the Maternal Health Desk Reference Cards sponsored and prepared by the Committee on Maternal Health, Michigan State Medical Association.

Sincerely,

Linda K. Harrison, RN, MPH
Perinatal Health Planner
Health Plan and Program
Development Division
Indiana State Board of Health
Indianapolis

(Editor's note: Copies of the desk reference cards are available from MSMS headquarters.)

". . . physicians and other health professionals."

I was impressed with the February 1977, Volume 76, Number 5 issue of MICHIGAN MEDICINE.

I would like to draw your attention to one error on page 65, column 1, second paragraph under number 2 ". . .not less than 1/3 of them physicians." The law (P.L. 93-641) states, "not less than 1/3 of the providers of health care who are members of the governing body or Executive Committee of a Health Systems Agency shall be direct providers of health care." Direct providers include physicians and other health professionals.

The interest of the Michigan State Medical Society in health planning is appreciated.

Sincerely,

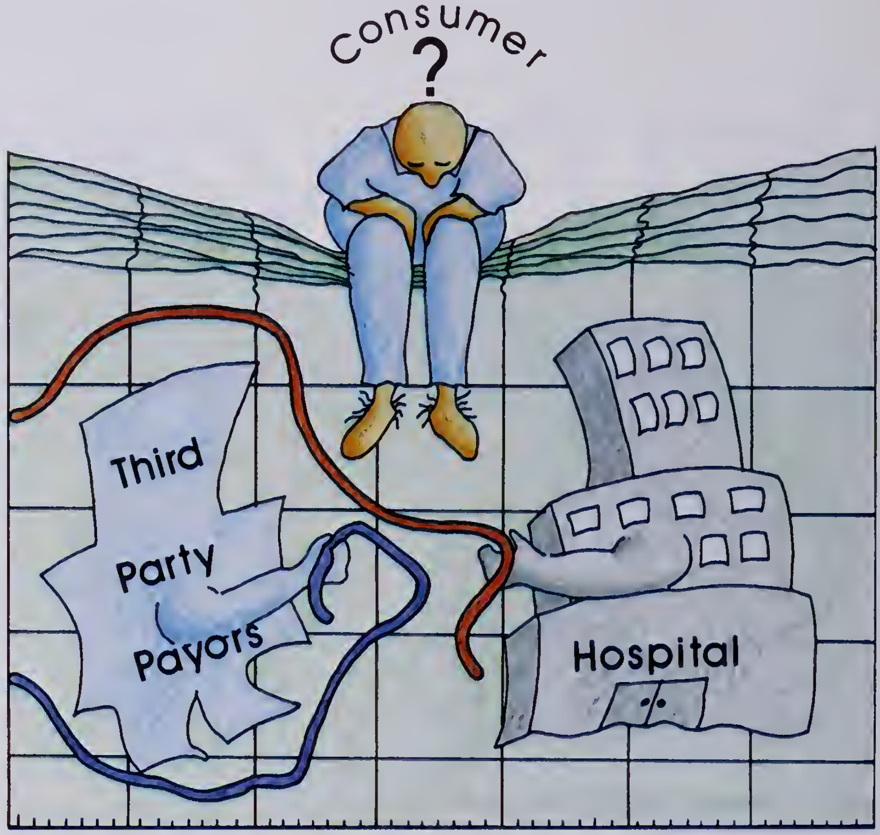
Philip E. VanHeest
Executive Director
West Michigan Health Systems Agency
Grand Rapids

". . . to inform your membership of our existence."

The Michigan Hodgkin's Disease Foundation has only recently been chartered with the State of Michigan, but already has a nucleus of 60 active and dedicated members. The intent of Michigan Hodgkin's Disease Foundation is to aid the patient in coping with the disease, to disseminate information via lectures and meetings, to establish procedures to raise and provide money for research, and to provide financial assistance to patients in need.

We have written this letter to inform your membership of our existence.

Gary Davidoff, President
Michigan Hodgkin's Disease Foundation, Inc.
P O Box 602
Plymouth, 48170



Cartoon by MSMS staff secretary, Kathy Minnerly.

Why normal supply/demand economics don't fit health care costs

By Elliot K. Wicks, PhD
East Lansing

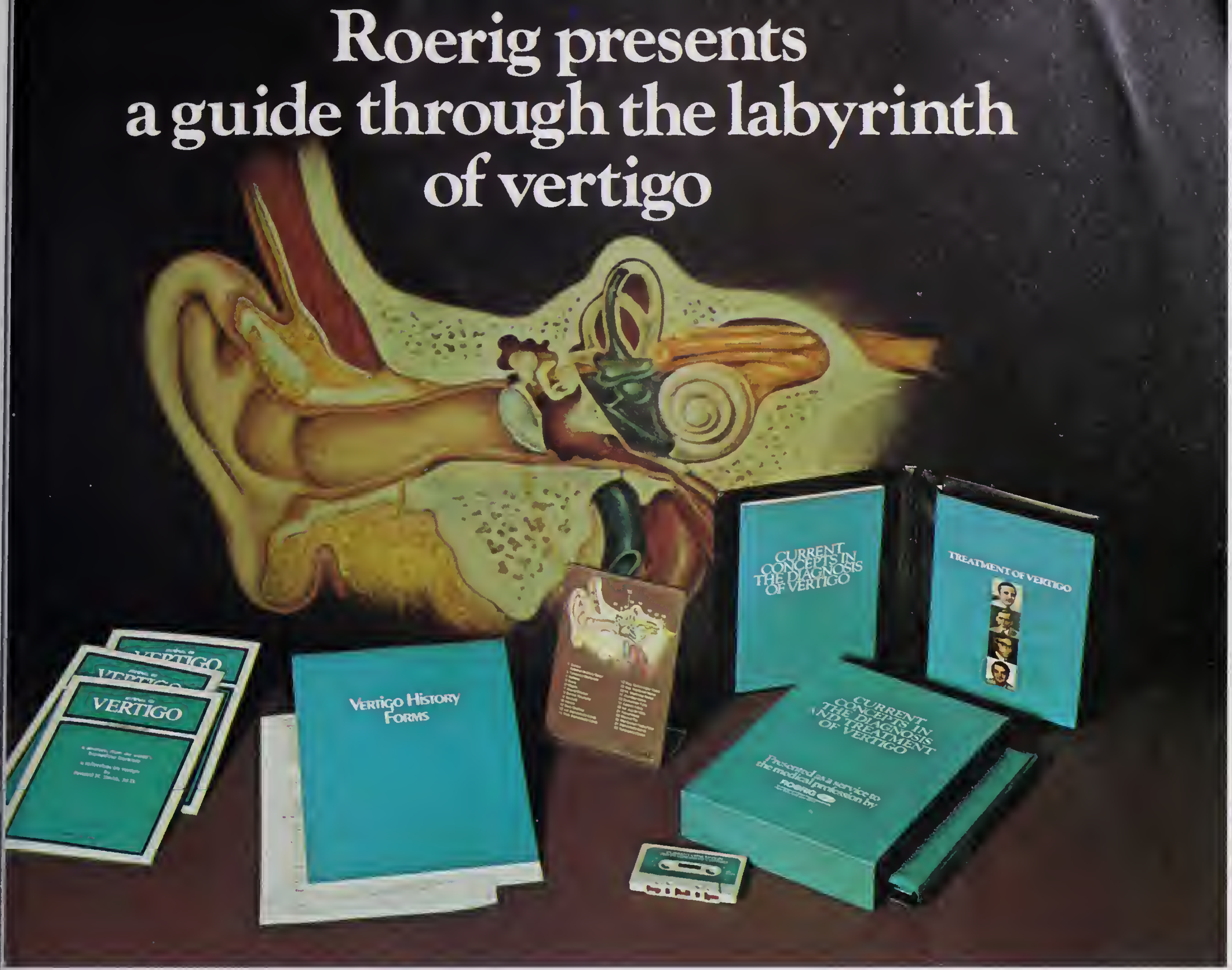
I suspect the majority of physicians are perplexed as to why the medical profession and the medical care industry have recently been singled out for so much negative attention. It is true that costs have risen rapidly, but the medical industry is not the only sector of the economy to experience this difficulty. In a society that subscribes to the principles of free markets and competition, does the fact of rising levels of expenditures and prices justify the rush to intervene in the medical economy?

It is understandable that physicians are wary of and even hostile to the prospect of government regulation. A high proportion of physicians have prospered under the capitalistic system of the American economy, and they share with most other Americans (and with economists) the view that the operations of the market generally provide an effective way of allocating resources. But what physicians may not understand is that the market operates well only when a whole series of conditions is satisfied, and the fact is that within the present delivery system for medical care very few of those conditions are satisfied.

In brief, an economy can be expected to perform well only when consumers are well informed about their needs and the capacities of potential purchases to satisfy those needs, when consumption is linked directly to paying a price that reflects the full costs of producing the product but

(Continued on page 232)

Doctor Wicks is on leave as a professor with James Madison College, Michigan State University and is a policy analyst and health planning consultant with the Office of Health and Medical Affairs, Department of Management and Budget, State of Michigan.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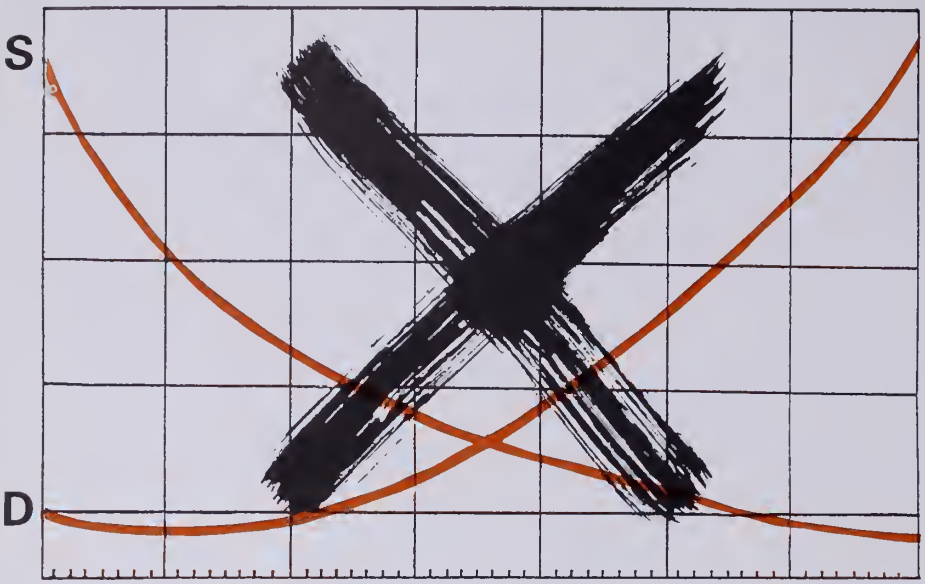

no more, and when producers supply those goods and services in a *competitive* market setting such that no single producer can influence price.

It does not take an economist to see that the health care industry fails to meet most of the conditions necessary for efficient market performance. And the failure can be traced directly to the medical delivery system. Providers and patients simply operate within this system and respond to its incentives. The result, unfortunately, is too often unacceptable performance.

It is vital that doctors recognize and understand this if they are to respond effectively and constructively to the kinds of criticism leveled against them and the system within which they work.

Consumer Ignorance and Provider Control

A major problem is the consumer's very limited knowledge about his medical needs and how they can be met. The ill person makes the decision that he needs medical attention, but he seeks a physician's aid for the very purpose of telling him what the nature of his illness is and what care is required to alleviate his condition.

In contrast to the case with most goods, the consumer is dependent upon the provider to tell him what kinds of services he needs, what quantities are required, and what alternatives are available. That dependence becomes increasingly great as medical services become more specialized and more technology-oriented, a price we pay for improvements in the quality and effectiveness of care.

The consumer's ignorance extends even to knowledge about the price of services; frequently not even the provider knows ahead of time what the cost will finally be. Likewise, the consumer has only minimal basis for assessing the quality of the product — even after he has consumed it. In short, the consumer's ignorance of the product is nearly complete; he has little choice but to accept the physician's word.

Consumer ignorance has a consequence of major significance: the kinds and quantities of medical services the consumer buys are determined to a very great extent by the *producers* of the service, not by the consumers. In economic terms, *suppliers determine their own demand.* This is important because suppliers are unlikely to be as keenly interested in keeping costs down as consumers would be.

Consumers, because they pay the bill when purchasing normal goods, naturally wish to limit costs; so they buy no more than optimum quantities and resist paying higher prices. But in the case of *medical* goods, the consumer is an ill and often frightened patient whose ignorance of the causes of his maladies and the alternative treatments makes him dependent upon the experts. He has little choice but to turn to the knowledgeable provider to make consumption decisions for him. Since there is no good substitute for proper medical attention when one is sick, the consumer is likely to make every effort to purchase whatever services the provider says are necessary, regardless of cost.

Such consumer dependence gives the supplier of services unique power to control both price and quantity of consumption — a situation which at best reduces incentives for economizing and at worst has the potential for abuse. Some instances of excess surgery and other forms of "over-doctoring" are surely traceable to exploitation of this control over demand.

But those relatively few providers who knowingly abuse their unique power to control demand probably contribute less to the problem overall than do the conscientious providers whose formost concern is their patients' health.

Even the most scrupulous provider simply does not have the incentive to economize that the consumer would. The provider sees his role as providing the best possible care for the patient. He is guided by the goal of improving the patient's condition rather than by the goal of economizing. The tendency of the health professional, therefore, is to utilize services as long as the additional utilization adds in any way to the patient's welfare. In contrast, the patient, *if* he knew enough to make an informed choice, would choose to utilize more services only so long as the expected benefits were greater than would be the benefits from spending the same amount for other non-medical purposes. But the consumer of medical goods is *not* in a position to make an informed choice. He has little choice but to consume what the professional advises. The result is a system which gives high priority to *quality,* or *effectiveness* — the extent to which the care improves the patient's condition — but little attention to *efficiency* — which is the ratio of effectiveness to *cost.* In fact, the concept of efficiency is often viewed (incorrectly) as a concept too coldly objective to be appropriate to apply when making decisions about providing health care.

It is in the sense that the medical system does not reward efficiency or penalize inefficiency. It encourages effectiveness but with little regard to cost. (The situation is analagous to an automobile dealer who could "prescribe" that all his customers buy Cadillacs rather than Chevrolets. The Cadillac admittedly represents higher quality, but for most people the Chevrolet provides completely adequate transportation; the marginal improvements in quality do not justify the extra expense of the Cadillac.) Thus, the ignorance of the medical consumer almost surely leads to higher levels of expenditures and costs than would be the case if the consumers themselves made the decision about how much medical care to consume relative to other goods. That result, it is imperative to note, is likely even if providers are motivated only by the medical interests of their patients and act in ways which are totally consistent with good medical practice.

Third-Party Payment

The diminished concern with economizing which is a consequence of provider influence over demand is greatly exacerbated by another major characteristic of the medical care system: the overwhelming importance of third-party payment. Insurance carriers and public programs pay for 67 percent of all personal health care expenditures. Direct payments by consumers out of pocket, therefore, account for only $1 of every $3 of the health care bill and for less than $1 of every $10 of hospital expenses, the most expensive kind of care.

To the consumer, this third-party payment appears as a reduction in the price of the service. The evidence shows that consumers respond to such a lowering of price by increasing the quantity or quality they consume. But it is a widely accepted economic principle that when price does not reflect the full costs of providing the service, consumers will demand (or acquiesce in their provider's demand for) an excessive amount of services. The consumer simply does not have the same incentive to resist price increases or to economize on utilization when the insurance company or the government pays anywhere from 80 percent to 100 percent of the bill, as is typical for good comprehensive coverage. The patient knows that he has already paid for the privilege of consuming services once he has paid his insurance premium or his taxes, and so when he needs those services, he is likely to demand "the best" care. Although he may realize that the high medical costs will be reflected in higher insurance premiums or increased taxes, he also knows that his *individual* consumption of care will have almost no perceptible effect on *total* costs.

When the provider knows the third-party payer rather than the patient will pay the bill, he too is unlikely to be cost-conscious. The physician will not hesitate to order elaborate tests and to deliver an expensive "style" of care when that is consistent with more accurate diagnosis and possible improvements in the patient's condition. It is almost certainly not a coincidence that the vast increases in hospital costs, brought on to a considerable extent by rapid adoption of very expensive technologies, have occurred in conjunction with rapid expansion of insurance coverage for hospital services. The existence of such insurance assures that such technologies will be paid for, but the technologies add to costs, thereby increasing demands for more extensive coverage. In short, the existence of insurance — an obviously necessary protection against high medical expenses — removes many of the incentives to economize and encourages higher levels of expenditures. Again, the prerequisites for optimum resource allocation through the workings of a market economy are not met.

Hospitals and Incentives

A third way in which the market for medical services differs from typical markets is that a major sector — the hospital sector — is dominated by nonprofit institutions. Community hospitals account for 78 percent of hospital expenses, yet only six percent of community hospitals are profitmaking institutions. Most noncommunity hospitals are also nonprofit. The significance of these facts is that such hospitals are not motivated by a desire to maximize profits, which is, of course, thought to be the major force promoting efficiency in typical economic institutions.

Although such hospitals do not try to operate so as to maximize profits, it is clear that they must at least "break even" by covering their costs. Even this apparently innocent objective tends to add to resource costs. A major portion of hospital costs are fixed costs that continue whether beds are empty or full. So unless the bed supply is tight, hospital administrators have no incentives to discourage long lengths of stay or admissions that are not absolutely necessary.

On the contrary, the administrator's task of assuring financial security is made easier if nearly all beds are usually full, since an empty bed brings in no revenue to apply to the fixed costs associated with that bed. When such incentives prevail, there is no pressure on physicians to economize on the utilization of hospital beds.

The result is that even when hospital bed supply is greater than appears to be defensible according to established norms, the beds nevertheless tend to be used. The high occupancy rates, in turn, appear to justify the number of beds available, even though better control of admissions and lengths of stay would eventually allow significant social savings since fewer hospital beds would be needed. It is this rationale which lies behind "certificate of need" laws and other regulatory activities to control the amount of hospital bed construction. From an economic perspective, such high utilization of hospitals is excessive; the extra cost is not matched by the extra benefits that the patient enjoys as a consequence of being an in-patient rather than an out-patient or from the longer stay. The result, however, is not "bad" medicine, just *uneconomic* medicine. Once again, the uneconomic use of medical resources can be traced to provider influence over demand, combined with extensive third-party payment.

If most hospitals are not motivated by profit maximization (beyond trying to achieve the minimum condition of covering costs), what goals do nonprofit hospitals strive to achieve? One reasonable hypothesis is that the goals include increasing the size of the institution and the quality of care. Since prestige is not gained by making profits, hospital staff, administrators and boards may attempt to receive recognition by having the biggest and best equipped hospital in the region. If hospital decisionmakers are so motivated, the almost certain result will be an increase in costs.

The consequence of this status competition among hospitals is much unnecessary and uneconomical duplication of facilities and capabilities. The notorious example is expensive open heart surgery facilities that are not used at anywhere close to optimum capacity. Of course, the costs of those facilities are ultimately passed on to consumers. (Yet consumers seldom complain because fully 92 percent of hospital costs are covered by third-party payment. The links between hospital costs, group health insurance premiums, and lower take-home pay are too nebulous and subtle to arouse consumers to act to compel hospitals to economize.)

The fact which makes this uneconomic hospital performance possible is the way in which hospitals are reimbursed: typically hospitals have been paid for the *cost* of each service. That is, whatever the hospital says the service costs to deliver is what the third-party pays. Such a cost-reimbursement system clearly removes the major pressures to be efficient and to keep costs down. A major source of increases, the rapid introduction of new technology, seems perfectly justified — it appears not as inefficiency but as an improvement in quality. Yet it is likely that if consumers were knowledgeable about their real needs and paid the full costs of these services directly, they would frequently not choose such "high style" care — especially since the service may have only very slight impact on improving health.

Again, it is apparent that the usual market factors which enforce efficiency and constrain costs do not operate for a critical sector of the medical economy. The importance of this fact should not be underemphasized, since hospital costs are 45 percent of total personal health care costs and have risen more rapidly in recent years than other medical costs.

In sum, the failure of "the market" can be traced, in large part, to three factors: (1) consumer ignorance and consequent control of demand by providers, (2) third-party payment of medical bills, and (3) an incentive system for hospitals which encourages high costs. These peculiar characteristics of the medical delivery system effectively nullify the usual capacity of the market system to allocate resources in an efficient and appropriate manner.

The ultimate consequences of market failure are all too familiar — rapidly escalating costs and levels of expenditure, with only marginal improvements in measurable indicators of health.

The Alternatives For Reform

What physicians and others concerned with improving the delivery of health care must realize is that "the market" cannot solve the problems of the medical care delivery system. Thus a defense of "free market" operation can't be justified in the medical economy as it currently exists. On the other hand, it is generally not appropriate to "blame" physicians or third-party payers or consumers for the problems of the system. The problem is *the incentive structure* – people are simply responding to the incentive structure in ways that promote their self-interest, a response which is generally thought to be entirely appropriate in our economic system.

But it should be clear that better performance requires substantial reforms.

One possibility is to try to make the market work better by changing the incentive structure: Health maintenance organizations and capitation payment systems, for example, are designed to make the *providers* of care, who control utilization, bear the burden of excess utilization. Insurance programs which include appropriate cost-sharing provisions give consumers financial incentives to economize. Education programs to instruct consumers in ways to utilize the delivery system appropriately and effectively promote both economy and quality. And prospective reimbursement systems are designed to force hospitals and other institutional providers to work to contain costs by tying the institutions to a fixed, predetermined budget.

The other basic approach is to recognize the deficiencies of the market and to correct them by substituting decisions by government or quasi-government regulation. This is the approach taken by those who favor health planning, rate regulation, and the like.

At this point, it is not at all clear how successful either approach will be. The likelihood is that we will get a dose of both.

But what is absolutely clear is that the status quo cannot continue. The groups paying the spiraling medical bills — consumers, employers, governments — simply will not stand for it. The criticisms will continue, and physicians must not fall into the trap of merely being defensive and attributing the criticisms to the imaginations of fertile journalistic minds or self-serving government officials. The defensive strategy is counterproductive because it only serves to confirm the suspicion, held by many, that physicians are a conservative group of privileged people interested primarily in protecting their positions of affluence.

The appropriate and constructive response is to recognize both the need for and the inevitability of change and to help shape the directions of change in ways that are compatible with the priorities and perspectives of the profession and yet responsive to the genuine problems.

The alternative is to be forced to accept a series of reforms that may be much less palatable and perhaps less effective.

(References available from the author.)

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The Blues elaborate on weekend admissions figures

From the Administration Division, Corporate Research Unit
Blue Cross/Blue Shield of Michigan

In its ongoing search for ways of reducing health care costs, Blue Cross and Blue Shield of Michigan is conducting studies which will determine why excessive or unnecessary costs occur in the delivery of health care. A report, "Length of Stay by Day of Admission," dated November 8, 1976, was distributed with the promise that further, similar reports would be published in the future.

This report, entitled "Factors Affecting Length of Stay," examines several factors which can affect differences between the average length of stay for weekend and weekday admissions.

The general findings are:

- The mix of patients admitted on weekends, in terms of age, sex, and diagnostic category, was found to be essentially the same as the mix of patients admitted on weekdays.

- The differences in length of stay between weekend and weekday admissions vary significantly among hospitals.

- The length of stay differences did not vary significantly by age-sex category, except for women 19-34 years old who had unusually small length of stay differences.

- The 1.7 day difference in length of stay for weekend vs. weekday admissions, pointed out in the first report, is attributable almost exclusively to surgical patients. Their length of stay difference was more than four days, as compared with approximately one-half day for non-surgical patients.

- Surgical patients admitted on weekdays wait on the average 2.6 days for surgery, while those admitted on weekends wait 5.1 days, or approximately twice as long. These figures vary significantly among hospitals.

It is recommended that hospitals perform additional studies related to these findings and institute appropriate changes in the scheduling of elective surgical admissions in order to avoid prolonged periods between the date of admission and the date that surgery occurs and/or active treatment begins.

In our first report, "Length of Stay by Day of Admission," released in November, 1976, it was found that on the basis of approximately a half million hospital cases in 1975, patients admitted to the hospital on weekends (Friday and Saturday) stayed in the hospital on the average about 1.7 days longer than patients admitted on weekdays (Sunday through Thursday). This 1.7 day "length of stay difference" between weekend and weekday admissions is a matter of great importance because of its implications regarding health care costs and is therefore the subject of the current phase of the continuing study.

This report will discuss some characteristics of the length of stay differences, illustrating in particular:

- The similarity in patient mix in terms of age, sex, and diagnostic category between weekday and weekend admissions.

- The variation among hospitals in the length of stay difference.

- The relationship of age and sex to the length of stay difference.

- The differences in length of stay between surgical and non-surgical patients by day of admission and by diagnostic category.

- The relationship between elapsed time to surgery and day of admission.

Data relevant to each of these items are presented and explained in the following sections.

Similarity of Patient Mix

The patient mix in terms of age, sex and diagnostic category is essentially the same for weekend admissions as for weekday admissions. Statistical tests show that minor differences in the patient mixes are not significant.

The analyses performed clearly indicate that differences in length of stay between weekend admissions and weekday admissions are not due to variations in age, sex or diagnostic category but rather to other factors which we feel are largely controllable.

The largest difference between the percentage of males in the various age groups admitted on the weekdays and those admitted on weekends is 1.8% (28.9% — 27.1% = 1.8%), which is for age group 55-64.

For females, a slightly greater variation is seen, although this variation is still insignificant, and does not show a pattern with age.

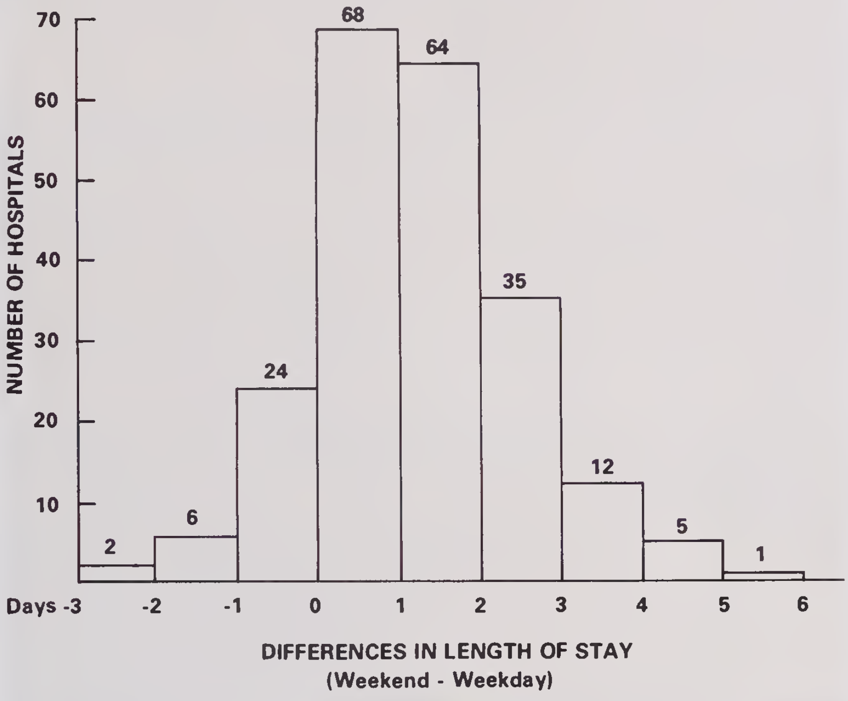
The distribution of surgical admissions by diagnostic category tends to be essentially the same for weekend admissions as for weekday admissions. In only three of the 17 groups is the difference in the percentages between weekend and weekday admissions greater than five percentage points, and in no case is it greater than 10 percentage points.

The distribution of non-surgical admissions by diagnostic category for weekday admissions is nearly identical to the distribution for weekend admissions. The largest difference in percentages is .9 percentage points which occurs for diagnostic category 800-999 (accidents, poisonings, and violence).

Variation Among Hospitals

As **Figure I** illustrates, there is considerable variation among hospitals in the extent to which length of stay for patients admitted on weekends differs from that of those admitted on weekdays. For more than half the 217 hospitals, the length of stay difference is between zero and two days. But for 35 hospitals, it is between two and three days and for 18 hospitals it exceeds three days. In 32 other hospitals, weekend admissions actually led to shorter lengths of stay than weekday admissions.

FIGURE I
DIFFERENCE IN LENGTH OF STAY BETWEEN WEEKEND AND WEEKDAY ADMISSIONS FOR 217 HOSPITALS



Age and Sex Characteristics

Table I shows that men admitted to the hospital on weekends stay in the hospital about 2.2 days longer than men admitted on weekdays. However, women stay only about 1.2 days longer when admitted on weekends. In order to explain this apparent difference between males and females, it is helpful to examine the pattern of the various age groups. For men, very little variation is found between the age groups, since the length of stay difference ranges only from 1.8 days to 2.3 days. However, for women, a great deal of variation is found with women in the 19-24 and 25-34 age categories having unusually small length of stay differences. One explanation for this is that many of the admissions for women aged 19-34 years are related to delivery. The first report pointed out that admissions for normal delivery experienced the same length of stay, regardless of the day of admission.

Surgical vs. Non-surgical Admissions

A comparison of 229,936 surgical admissions with 275,125 non-surgical admissions shows that surgical pa-

Table 1
Length of Stay Differences By Age-Sex Classifications Weekend vs. Weekday Admissions*

Sex Age	Male	Female
19-24	1.9 days	0.4 days
25-34	1.8	0.5
35-44	1.9	1.9
45-54	2.3	2.6
55-64	2.2	2.4
65 +	1.8	2.6
WEIGHTED AVERAGE	2.2	1.2

*1975 annual hospital data. Age groupings are not given for persons less than 19 years old because data for this group classified by sex are not available.

Table 2
Difference In Length of Stay Between Weekend and Weekday Admissions Classified by Diagnostic Category and Surgical vs. Non-Surgical Admissions*

DIAGNOSTIC CATEGORY	DIFFERENCES IN LENGTH OF STAY BETWEEN WEEKDAY AND WEEKEND ADMISSIONS	
	Surgical	Non-Surgical
000-136 (Infective)	4.60 days	0.39 days
140-239 (Neoplasms)	6.38	0.99
240-279 (Metabolic)	8.01	0.69
280-289 (Blood)	3.95	0.00
290-316 (Mental)	3.40	0.26
320-389 (Nervous System)	2.92	0.31
390-458 (Circulatory System)	6.58	0.93
460-519 (Respiratory System)	2.51	0.26
520-577 (Digestive System)	3.17	0.55
580-629 (Genitourinary System)	1.67	0.34
630-678 (Pregnancy)	**	0.00
680-686 (Skin)	5.25	0.31
710-738 Musculoskeletal System)	5.85	1.31
740-759 (Congenital Anomalies)	5.83	2.97
760-779 (Perinatal)	0.71	−0.69
780-796 (Ill-Defined)	3.67	0.52
800-999 (Accidents, etc.)	2.34	0.29
000-999	4.14	0.40

*1975 data.

**For the purposes of this study all maternity cases are shown as non-surgical admissions.

tients stay approximately four days longer in the hospital if admitted on weekends, whereas non-surgical patients on the average spend only an extra half day in the hospital if admitted on the weekend. Surgical patients for each diagnostic category have a much higher length of stay for weekend admissions than for weekday admissions. However, the size of the length of stay difference varies significantly by diagnostic category.

As shown in **Table 2,** non-surgical patients have in general only slightly longer lengths of stay for weekend admissions, regardless of diagnostic category.

Elapsed Time to Surgery

Surgical patients admitted on weekends wait on the average 5.1 days for surgery whereas those admitted on weekdays wait only 2.6 days. Thus there is a difference of 2.5 days, showing that patients admitted on the weekend wait significantly longer for surgery than those admitted during the week. This can indicate that surgical patients admitted on weekends may not be receiving active treatment or having necessary diagnostic procedures performed for several days.

Note further that the same phenomenon occurs even if the data are controlled for age, sex, and diagnostic category. In **Table 4** data on elapsed time to surgery for males in age group 25-34 with diagnoses in category 140-239 (neoplasms) are given. This particular age, sex, and diagnostic category was chosen in order to obtain a reasonably large number of cases. A comparison of the 2.8 day difference found in **Table 4** with the 2.5 day difference shown in **Table** 3 indicates that the pattern for this age, sex, diagnostic category is typical of the overall pattern.

The overwhelming majority (74.6%) of surgical cases admitted on weekdays are operated on the day following admission. 91.9% of the patients are operated on during the first four days of hospital stay. **Figure** 3 illustrates this behavior.

The distribution of elapsed time to first surgery for weekend admissions (**Figure** 4) contrasts sharply with that for weekday admissions. While 30.5% of surgical patients admitted on the weekend receive surgery on the day of admission compared with only 8.4% for weekday admissions, only 52.2% of patients admitted on weekends are operated on within the first two days compared with 83% for weekday admissions.

Conclusion

The report on the first phase of the continuing study of hospital admissions showed that patients admitted on weekends stay in the hospital about 1.7 days longer than patients admitted during the week. The second phase of the study examined several factors related to this 1.7 day length of stay difference.

It was found that:

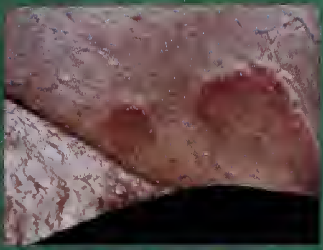
- The mix of patients admitted on weekends, in terms of age, sex, and diagnostic category, was found to be essentially the same as the mix of patients admitted on weekdays.
- The differences in length of stay between weekend and weekday admissions vary significantly among hospitals.
- The length of stay differences did not vary significantly by age-sex category, except for women 19-34 years old who had unusually small length of stay differences.
- The 1.7 day difference in length of stay for weekend vs. weekday admissions, pointed out in the first report, is attributable almost exclusively to surgical patients. Their length of stay difference was more than four days, as

(Continued on page 241)

When Griseofulvin is indicated...

TINEA PEDIS*

TINEA UNGUIUM*



TINEA CRURIS*

TINEA CAPITIS*

*Also *Tinea barbae* and *Tinea corporis* when caused by fungi from genera known to be sensitive to griseofulvin.

Gris-PEG®
(griseofulvin ultramicrosize)
Tablets 125 mg
offers effective therapy with 1/2 the dose.†

- Can be taken on an empty stomach
- Absorption nearly complete without fatty meals
- Reduced cost for patients
- Once-a-day or b.i.d. dosage

†250 mg of Gris-PEG® provides plasma levels equivalent to those obtained with 500 mg microsize griseofulvin. This improved absorption permits the oral intake of half as much griseofulvin but there is no evidence, at this time, that this confers any significant clinical difference in regard to safety or efficacy.

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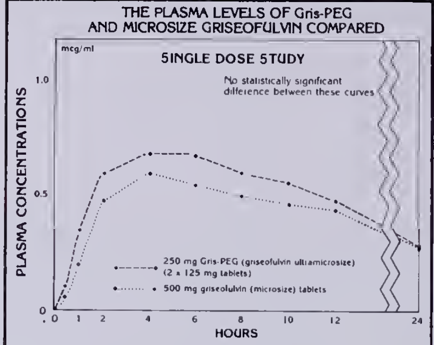
Please see other side for full prescribing information.

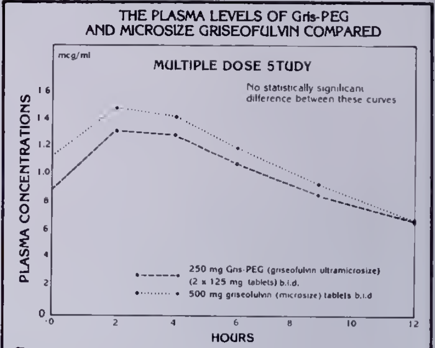
Gris-PEG®

(griseofulvin ultramicrosize) Tablets 125 mg

The ½ dose griseofulvin.



Based on a single dose double-blind bioavailability study conducted in 24 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels. There is no significant difference between peak plasma levels, times to peak, and areas under the curve. Gas chromatographic assay.



Based on a double-blind multiple dose steady state crossover bioavailability study conducted in 17 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels obtained on days 9, 11 and 13. There is no significant difference between times to peak, peak plasma levels, and areas under the curve. Gas chromatographic assay.

DESCRIPTION
Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION
Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum*, *Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsized griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy.

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS
Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections.

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis; ringworm of the nails)

when caused by one or more of the following genera of fungi:

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleini
Microsporum audouini
Microsporum canis
Microsporum gypseum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *not* effective in the following:

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS
This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS
Prophylactic Usage: Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5-2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy: The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress.

Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS
Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists, however, known penicillin-sensitive patients have been treated without difficulty

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS
When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSAGE AND ADMINISTRATION
Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6 weeks; *tinea corporis*, 2 to 4 weeks; *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months; toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsized), USP (see ACTION Human Pharmacology).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis, tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis, the following dosage schedule for children is suggested:

Children weighing over 25 kilograms (approximately 50 pounds)—125 mg to 250 mg daily.

Children weighing 15-25 kilograms (approximately 30-50 pounds)—62.5 mg to 125 mg daily.

Children 2 years of age and younger—dosage has not been established.

Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED
Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin (microsize) tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsized griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsized griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.

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OY-YB

Table 3

Elapsed Time to Surgery by Day of Admission*

Day of Admission	Number of Cases	Average Elapsed Time To Surgery
Sunday	4,707	2.4
Monday	5,173	2.6
Tuesday	4,849	2.7
Wednesday	4,663	2.6
Thursday	4,282	2.4
Sunday-Thursday	23,674	2.6
Friday	1,672	4.8
Saturday	1,070	5.6
Friday and Saturday	2,742	5.1

*Based on the portion of second quarter 1976 data available at present. It is estimated that this is about 23% of total second quarter data.

Table 4

Elapsed Time To Surgery For Males 25-34 Years Old In Diagnostic Category 140 - 239 (Neoplasms) Classified by Weekend vs. Weekday Admissions*

Period of Admission	Number of Cases	Elapsed Time To Surgery
Sunday-Thursday	7,185	3.1 days
Friday and Saturday	912	5.9 days

*Based on the portion of second quarter 1976 data available at present. It is estimated that this is about 23% of total second quarter data.

FIGURE 3
DISTRIBUTION OF ELAPSED TIME TO FIRST SURGERY
SECOND QUARTER 1976
SUNDAY — THURSDAY ADMISSIONS
23.1% MATCHED SAMPLE

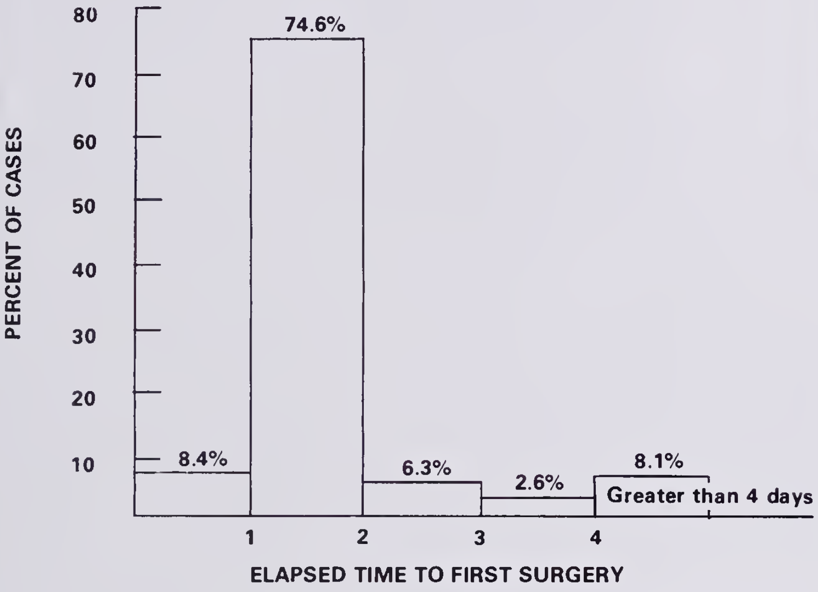
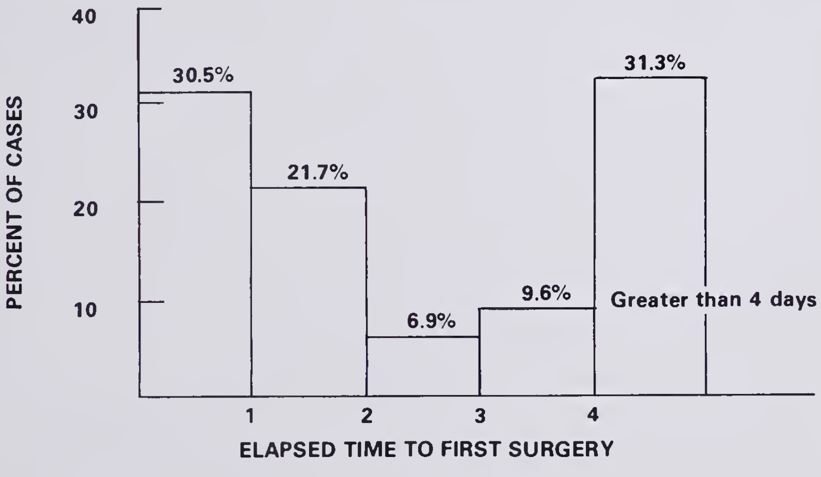


FIGURE 4
DISTRIBUTION OF ELAPSED TIME TO FIRST SURGERY
SECOND QUARTER 1976
FRIDAY — SATURDAY ADMISSIONS
23.1% MATCHED SAMPLE



compared with approximately one-half day for non-surgical patients.

- Surgical patients admitted on weekdays wait on the average 2.6 days for surgery, while those admitted on weekends wait 5.1 days, or approximately twice as long. These figures vary significantly among hospitals.

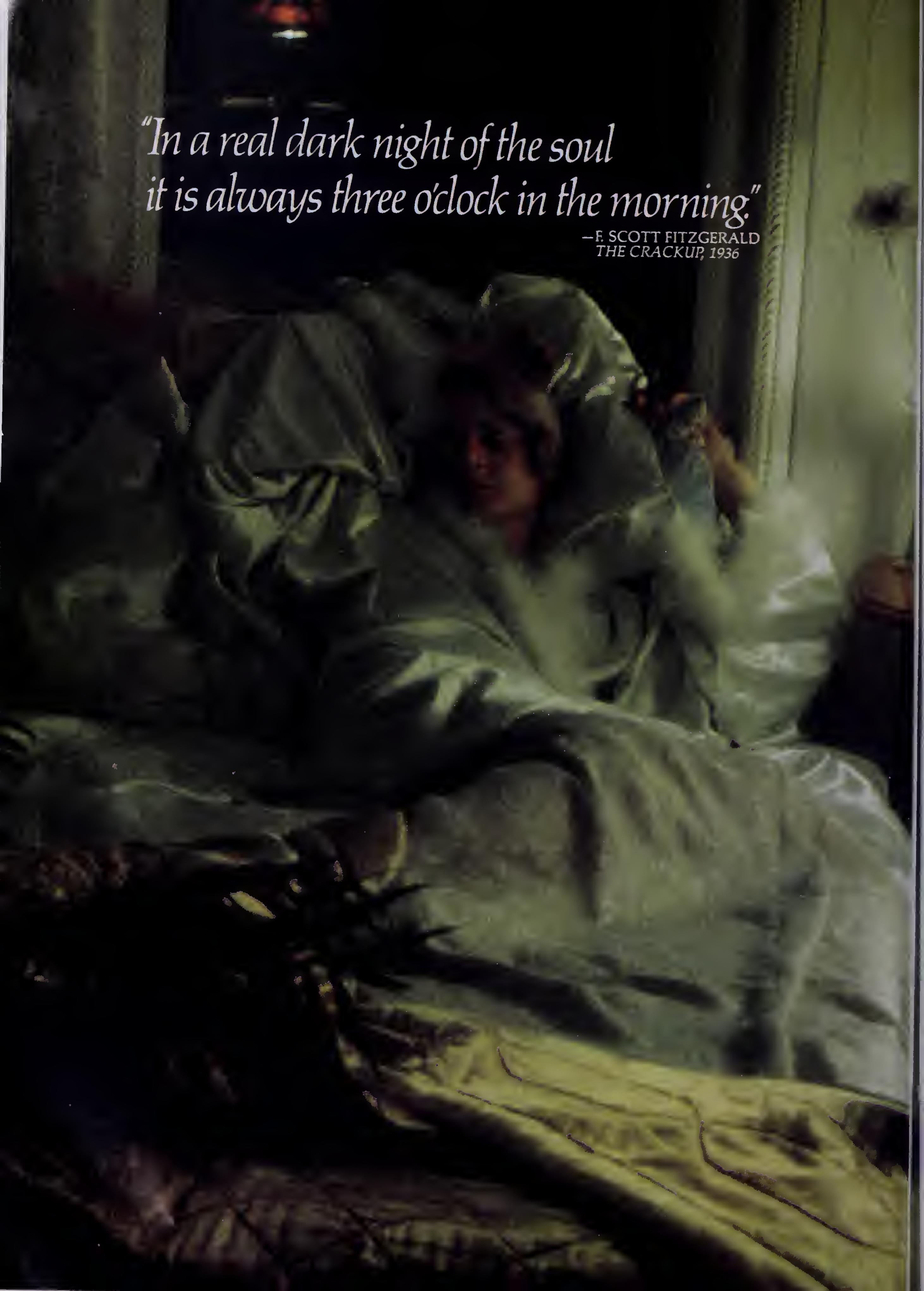
It is believed that hospital administrators, physician staffs, Cost Containment Committees and Utilization Review Committees working together can resolve the problems identified in this report. Specifically, the following actions should be considered:

- Perform additional in-hospital studies or analyses, where needed, to identify the precise causes of the problems and institute appropriate policy or procedure changes.

- Schedule elective surgical admissions as close as possible to the planned date of surgery.

- Avoid prolonged periods between the date of admission and the date that active treatment or required testing begins.

(Continued on page 244)



> *"In a real dark night of the soul*
> *it is always three o'clock in the morning."*
>
> —F. SCOTT FITZGERALD
> *THE CRACKUP, 1936*

Insomnia
a shade of blue that often accompanies depression

And, in anxiety/depression, Adapin® (doxepin HCl) often helps restore disturbed sleep patterns, such as early morning awakening, with a single daily dose at bedtime.[1] Adapin quickly relieves the patient's anxiety, gradually brightens his mood and outlook, with optimal antidepressant response usually evident within two to three weeks.

[1] Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information
ADAPIN® (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, or on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

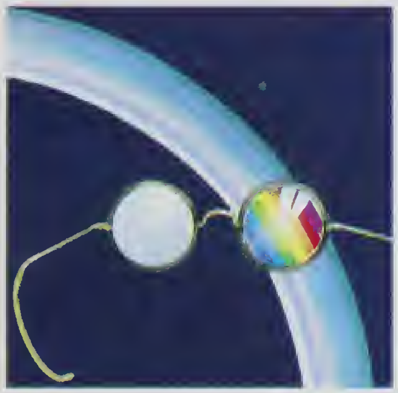
Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 10 mg to 25 mg t.i.d. Increase or decrease the dosage according to individual response. **Usual optimum daily dosage is 75 mg to 150 mg** per day, not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg and 50 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.



When they see life in shades of blue... help them see life in all its colors.

Adapin®
(doxepin HCl)

single daily dose recommended h.s.

10-mg capsules
25-mg capsules
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How MDs see the situation

Doctor Musson

"Statistics . . . do not really explain why . . ."

By Kenneth H. Musson, MD
Traverse City

Statistics may be used to identify an area of problem utilization, but they do not really explain *why* apparent variations exist. Study of individual case records from the hospitals cited by Blue Cross/Blue Shield should demonstrate whether utilization is justified or not.

Many factors will produce apparent prolongation of hospitalization, yet there may be justification. Accident admissions are twice as frequent on weekends and may require several days to stabilize prior to definitive surgery. There may be patients with significant concomitant medical problems, or patients who require specialized preparation that will extend preoperative stay. It is not unreasonable to do this preparation over a weekend so that shorter stay surgical patients can be better accommodated during the weekdays.

"Full service" hospitals may be better able to provide services preoperatively, over a weekend, and not have a significant increase in length of stay. Of the hospitals studied, less than nine percent exceeded a three-day preoperative stay, but 15 percent had a shorter stay for those patients admitted on a weekend compared to weekday admission.

If patients are admitted several days prior to surgery just for the convenience of the patient, physician, or hospital, without medical justification, then utilization is being abused.

P.S. The hospital administrator at Munson Medical Center just told me that when he reviewed a number of these cases he found that the statistical sample was not valid. Many cases were medical, had diagnostic surgical procedures, etc., and were not truly surgical admissions. You may wish to mention this.

Doctor Musson is a member of the MSMS Committee on Third Party Carriers.

". . . a surprise to us surgeons . . ."

By Marion G. McCall, MD
Detroit

I am pleased the editor has assured me these comments will appear *with* the report that follows. While it makes vitriolic replies tough it is somehow reassuring to know that the report has at least been available, if not read, before blunder pens are hoisted.

It certainly comes as a surprise to us surgeons that the excess stay seems to be in surgical patients — and after all these years of accusing internists of hogging all the beds. Surgeons certainly are tempted to apologize sheepishly to their internist friends — but of course, no surgeon would ever apologize. He's far more likely to question whether the division of diagnostic categories into surgical and non-surgical ought not be based on outcomes and if so will ask if the seemingly poor surgical performance might not be due to the internists bringing them in a few days early — hogging the beds again.

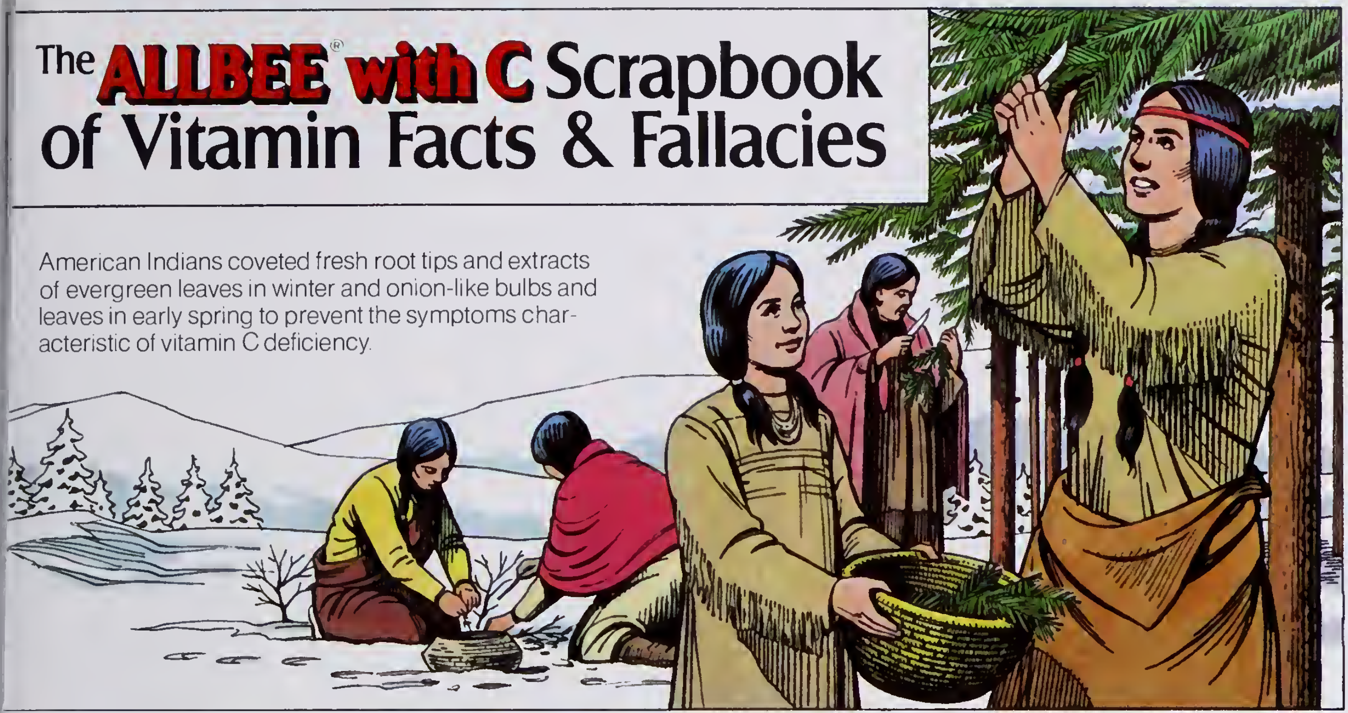
Unfortunately the report doesn't answer that but at least the temptation to apologize is avoided for now. There are things in the report that suggest the surgeon might be right. For instance, 75% of weekday admissions presumably by surgeons are operated the next day and by third day 89% are recuperating. Surgeons seem to admit for scheduled surgery. The Blues will have to provide us more information, hopefully directly to those medical staffs that seem to be at greatest variance.

Doctor McCall is an MSMS councilor.

(Continued on page 247)

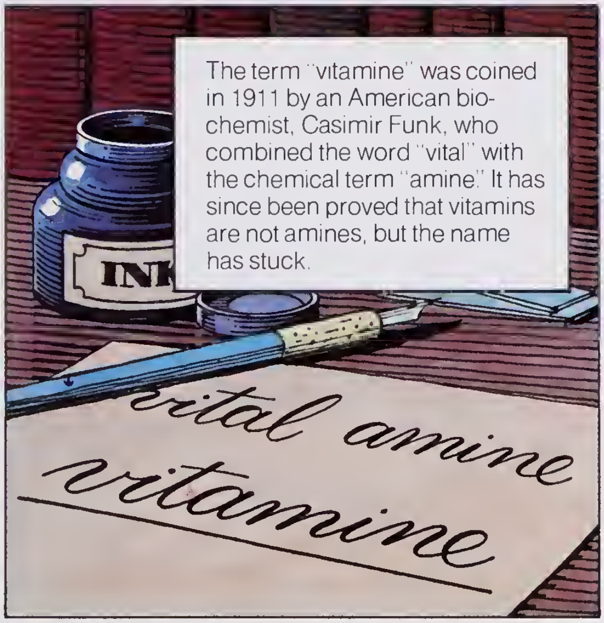
The ALLBEE® with C Scrapbook of Vitamin Facts & Fallacies

American Indians coveted fresh root tips and extracts of evergreen leaves in winter and onion-like bulbs and leaves in early spring to prevent the symptoms characteristic of vitamin C deficiency.

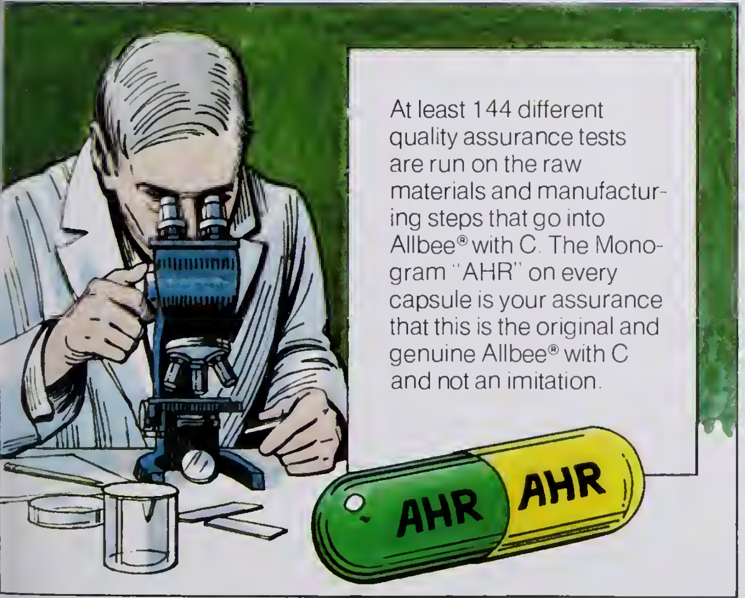


A tomato is botanically classified as a berry!

It is ironic that many of the vegetables highest in vitamin C and riboflavin are considered unappetizing by many people. These include turnip greens, kale, chard, mustard greens, spinach, water cress, broccoli and brussels sprouts.


INK
vital amine
vitamine

The term "vitamine" was coined in 1911 by an American biochemist, Casimir Funk, who combined the word "vital" with the chemical term "amine." It has since been proved that vitamins are not amines, but the name has stuck.



At least 144 different quality assurance tests are run on the raw materials and manufacturing steps that go into Allbee® with C. The Monogram "AHR" on every capsule is your assurance that this is the original and genuine Allbee® with C and not an imitation.

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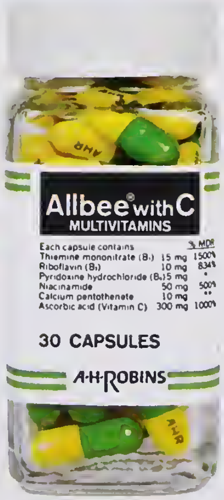
Allbee® with C
MULTIVITAMINS
Each capsule contains % MDR
Thiamine mononitrate (B₁) 15 mg 1500%
Riboflavin (B₂) 10 mg 834%
Pyridoxine hydrochloride (B₆) 5 mg *
Niacinamide 50 mg 500%
Calcium pantothenate 10 mg **
Ascorbic acid (Vitamin C) 300 mg 1000%
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Spasm reactor?
Donnatal®!

	each tablet, capsule or 5 ml tsp of elixir (23% alcohol)	each Donnatal No. 2 Tablet
Phenobarbital (warning: may be habit forming)	(¼ gr) 16.2 mg	(½ gr) 32.4 mg
Hyoscyamine sulfate	0.1037 mg	0.1037 mg
Atropine sulfate	0.0194 mg	0.0194 mg
Hyoscine hydrobromide	0.0065 mg	0.0065 mg

Indications: Based on a review of this drug by the NAS/NRC and/or other information, FDA has classified the following indications as possibly effective: adjunctive therapy in the treatment of peptic ulcer; the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

Brief summary. Contraindicated in patients with glaucoma, renal or hepatic disease, obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy) or a hypersensitivity to any of the ingredients. Blurred vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur at higher dosage levels, rarely at the usual dosage.

A·H·ROBINS A H Robins Company Richmond Virginia 23220

". . . like blunderbuss hipshooting . . ."

By Leland C. Holly, MD
Muskegon

The sadness is that this data has been available for several years. For that long we providers have sent BC/BSM this and other data for which we have not got much helpful in return.

The history is that BC/BSM bases action on unilaterally interpreted data without provider input regarding what the data means in the real world. BC/BSM responses have been like blunderbuss hipshooting at a sound target in a dense forest. All the friendly animals get killed but the target slips away.

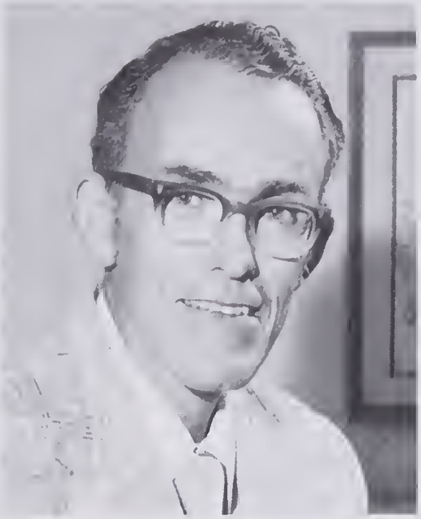
The caution is that BC/BSM has very little credible expertise about the actual delivery of medical care because, like Donald Duck, dollar signs in its eyes obscure its careful evaluation.

The hope is that BC/BSM data assembly and use will have as their primary goal better medical care; that data reliability and conclusions will be assessed by competent provider groups; that BC/BSM programs will be directed selectively and accurately.

The joy is that BC/BSM has geared up those high-priced computers — I hope this study wasn't done by hand — to identify, correlate and analyze this data segment in a manner which may help us do our jobs better.

This study deserves our careful consideration and response.

Doctor Holly is chairman, MSMS Finance Committee.



Doctor Holly

". . . impossible to put any adverse connotation . . ."

By Robert E. Rice, MD
Greenville

Apparently the second phase of the length of stay study turned up the fact that: 1. A few hospitals have a longer length of stay than the majority of hospitals. 2. Weekend surgical admissions have a longer stay than weekday surgical admissions.

The hospitals in which the length of stay seems to be excessive from the statistical standpoint are not so numerous that they could not be studied a little more closely to determine if the length of stay is medically justified or not. The reasons affecting the length of stay are not always obvious from pure statistics, and a proper evaluation could probably determine the relationship between the statistics and the actual situation. There is a chance that the length of stay might be found to be unacceptable, or on the other hand, justified.

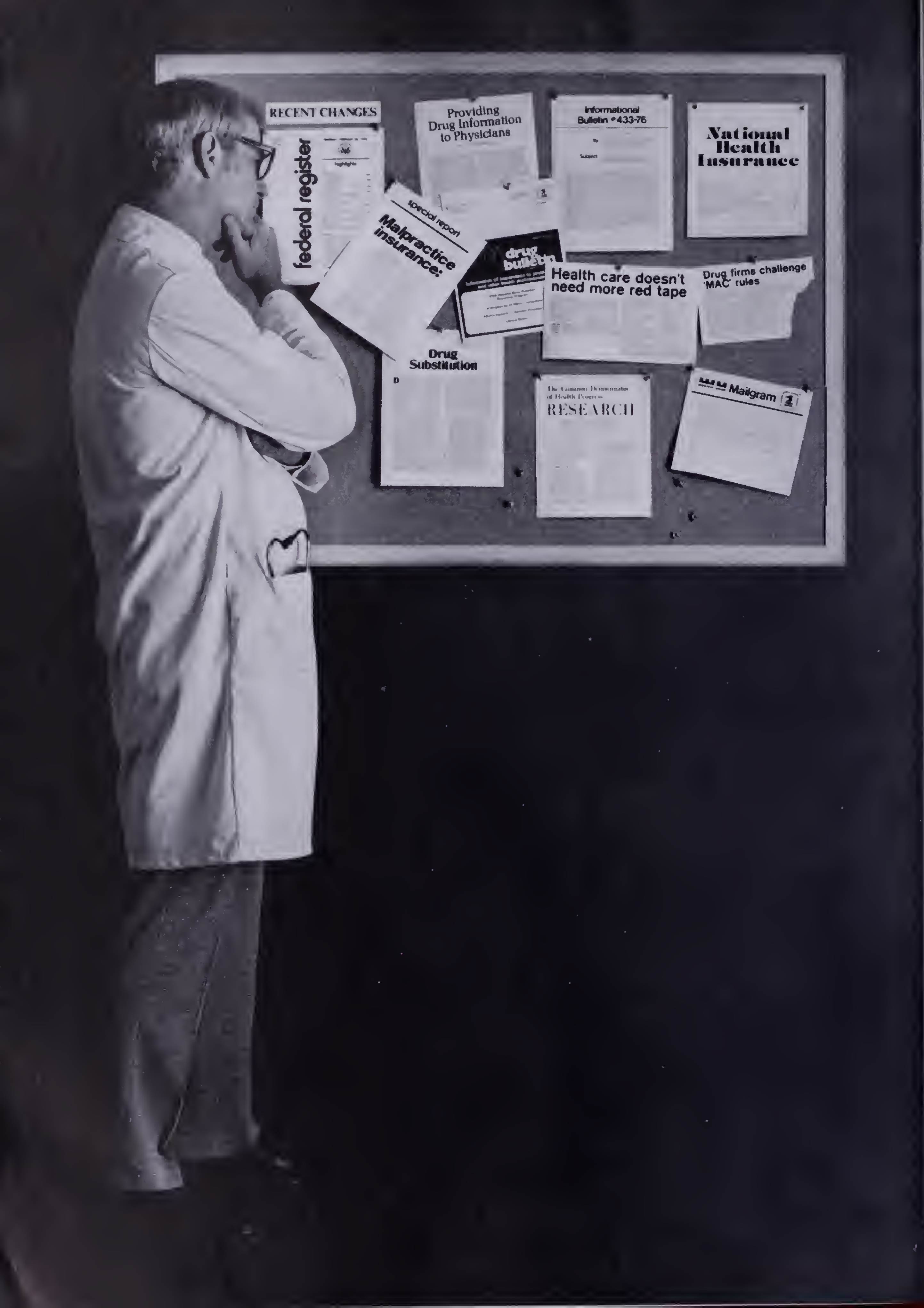
The other proposition that surgical weekend admissions have a longer length of stay than weekday surgical admissions is probably in a different sphere of consideration. It is incumbent upon those interested to make a more detailed study of these admissions relative to the necessity of the days of hospitalization.

The statistics show a greater number of trauma cases admitted on the weekends, most of which would be admitted as surgical cases. These patients might well need more management and more days of management than the ordinary surgical admission.

In addition to the trauma cases, it is also very likely that patients with other surgical diagnoses in the various categories that were ill enough to be admitted on the weekend might also be sicker and require more complicated management and more lengthy management. With-

(Continued on page 250)

Doctor Rice


RECENT CHANGES
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Drug firms challenge 'MAC' rules
Drug Substitution
The Common Denominator of Health Progress
RESEARCH
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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

out knowing the details of these cases that are described as a longer stay. it is impossible to put any adverse connotation on the length of stay.

It seems to me it would be advantageous for the physicians and hospitals as well as those responsible for paying the bills to look into these two problems, especially the latter, with enough thoroughness to be satisfied that the judgment, either good or bad, is defensible.

Doctor Rice is chairman of the MSMS delegation to the AMA.

Doctor Bryan

". . . personal experience in accord . . ."

By John B. Bryan, MD
Royal Oak

As an internist, my personal experience is that admitting my patient on a weekend doesn't vary the length of his stay significantly from those admitted on a weekday. This is because most admissions are prompted by a medical emergency, and my patient and I are served by hospital personnel who are available seven days a week — namely, the Emergency Center (and Observation Area), CCU, labs and X-ray department.

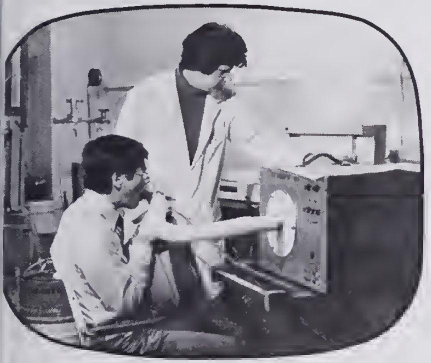
Such personal experience is in accord with the data in the BC/BSM report on "Factors Affecting Length of Stay" (in hospital). The Executive Summary notes "approximately one-half day" additional stay when admitted on Friday or Saturday for "non-surgical" care.

My few occasions to observe any delay in care, which must have contributed to prolongation of the length of stay, include certain specialized diagnostic and therapeutic procedures, usually done by a single specialist, who can hardly be asked to work seven days a week. These include my colleagues who pass catheters for various angiographic studies (though I may ask and they shall place a temporary transvenous pacemaker at any hour of any day for my patient.) And, my surgeon consultants are obliged to schedule elective procedures wherever they can penetrate the OR schedule. Ditto endoscopists.

Recognizing that such may delay my patient by an average of "1.7 days," I've given much thought to a solution at my primary hospital. And, without discussing it with administrators, I believe it may cost *more* to fully staff and operate a full service hospital 365 days a year than the additional cost produced by the extra "1.7 day" length of stay would cost. I would expect that our hospital administrators have come to such a conclusion, or we would all enjoy seven-day/week service from all hospital personnel. Simple logic indicates that premium salaries for weekend work at "time and a half" and "double time" rates exceeds "1.7 days" at par.

Doctor Bryan is president of the Oakland County Medical Society.

"Every doctor of medicine licensed to practice within this state shall...apply to the state medical board for a certificate of triennial registration.... The applicant shall include satisfactory evidence to the board that in the preceding three years the practitioner had completed 150 hours of continuing medical education..."



To help you fulfill specialty society, medical association, and state board CME requirements (like the Ohio statute quoted above), the Network for Continuing Medical Education (NCME) offers:

- 10 hours of programming a year that qualify for AMA Category 1 and AAFP Prescribed or Elective credit;
- a computerized record of your CME activity;
- the convenience of outstanding medical education at your hospital on videocassette every two weeks.

Some typical NCME Category 1 topics for 1977:

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- Dermatology Workshop
- Drugs for the Menopause
- Diagnosis of Hyperthyroidism
- Clinical Immunology Update

Faculty for NCME programs are drawn from the nation's outstanding medical schools and teaching hospitals.

The cost? Surprisingly low. Because of continuing support from Roche Laboratories, subscription fees cover little more than the costs of raw videocassette stock, mailing, and handling.

For detailed information about this unique service, complete and mail the coupon below. Or pass this advertisement on to a colleague with responsibility for continuing education at your institution.

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The articles on this and the following two pages could be the most important you read all year.

Doctor, check here: are your patient relations good?

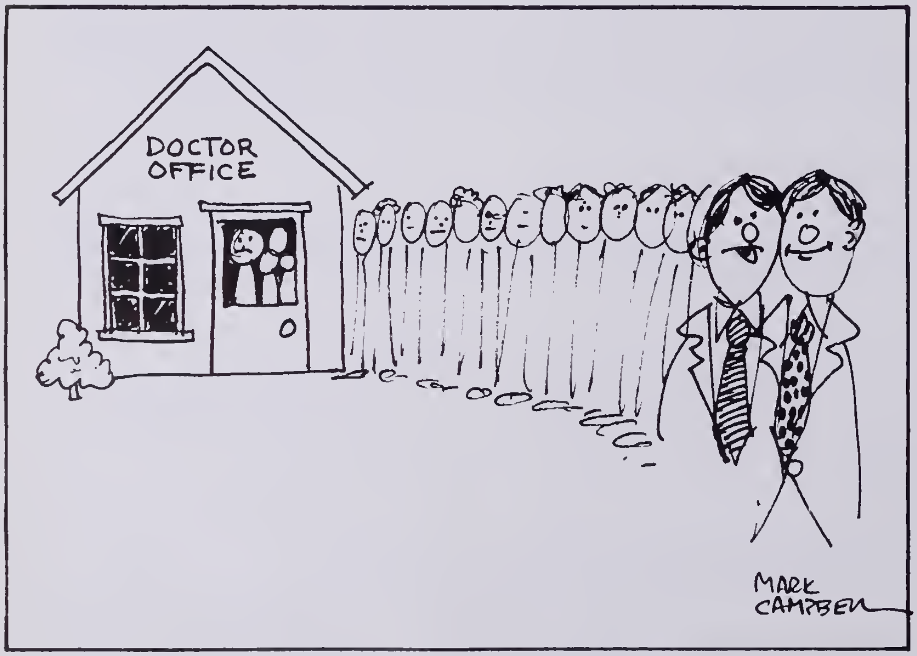
By Elmer White
Special to Michigan Medicine

The real key to a fine relationship is simply a demonstration by doctor and staff that they care. Consideration is the word. Much can be forgiven and forgotten if patients feel discomfort is truly regretted.

It is easy for doctor and staff to take office procedures for granted; especially when everyone is busy. But physicians should try to make a trip to the doctor as pleasant as possible.

Patients sometimes must wait long periods when they are feeling less than their best. They can be extra sensitive, especially when there is little to do but fret about discomfort or time lost.

What can the doctor do? He can care about his patients' comfort and state of mind. Here are some specific points which permit a doctor to evaluate his own office. Check your standing, if you wish.



Any longer wait and we will have squatter's rights to the land.

Excellent **Needs Attention**

☐ ☐ *Waiting Room.* Is it pleasant? Clean, light, well-ventilated, proper humidity and temperature? Are seating facilities comfortable? Are there signs about smoking? Non-smokers appreciate them and are becoming more belligerent about a supply of clean air.

☐ ☐ *Reception.* Are there provisions to receive patients in a reasonably brief time? Is any effort made to segregate those with coughs, wheezes, fevers or rashes? Some patients, especially mothers with small children, worry they are exposed more to disease in a doctor's office than anywhere else.

Is the reception courteous? The distressing fact is that some receptionists are not always so. Brusqueness and discourtesy, against which patients usually feel helpless, build resentment.

Doctors would do well to chat now and then with patients to see if they feel they have been treated reasonably while waiting. They should remind staff members of the importance of consideration to all patients at all times. True professionals treat patients with courtesy and understanding.

☐ ☐ *Reading Material.* It should also be considered an obligation to provide something to help pass time more pleasantly, particularly when the doctor is behind schedule.

How about pamphlets on various topics of health? A number are available, and there is opportunity for greater use to supply information. Leaflets can deal with aging, pregnancy, growing up, VD, drug problems, and other common medical subjects.

Messages could be available about doctors' problems that affect patients. Suitable subjects might be malpractice insurance and bills, forms for health insurance, Medicare and Medicaid, the need for patients to follow the doctor's instructions.

A report on medical activities in the area might be appropriate, or a review of the doctor's day. Few patients realize, for example, that many doctors donate their services to local clinics regularly, or how hard they work to keep up with new medical information.

A week's supply of the doctor's reading put on display would impress many patients. The number of meetings a doctor must attend is substantial. The length of the work day is an impressive figure, as well as the required 50 credits in extra training.

In short, information which helps a waiting patient appreciate a doctor's problems can be helpful.

☐ ☐ *Examining Room.* Patients get cold during long waits. They get bored. They get increasingly uneasy.

Be sure the examining room is as comfortable as possible. How about reading material here? Have appropriate art on the walls. The Hippocratic Oath, a truly noble statement, might be read carefully by patients who pace the room while waiting.

☐ ☐ *Meeting the Doctor.* To the patient, the entry by the doctor is a high point. The most important thing a doctor can do (except for providing expert service) is to show the patient he really cares about him as an individual. The bedside manner which served doctor and patient so well for so long has no substitute today.

Greet the patient with a handshake and a smile. Ask about the family. Listen to the answers and react appropriately. After examination, take time to talk with the patient. Tell him briefly what you think about his condition. Stress your instruction about medicine or procedures.

Ask and invite questions to be sure he understands. Suggest he bring written questions next time. This saves doctors' time while it evidences interest in the patient's emotional tranquility. Try to be sure the patient has a grasp of what is expected of him when he leaves.

☐ ☐ *Presenting the Bill.* This is a "necessary evil" from the patient's standpoint, so it comes as no surprise. It should, however, come as promptly as possible, be clearly understandable, and be presented with courtesy. A common complaint about billing is that patients who have questions must discuss them with others nearby. Provide as much privacy as possible to eliminate this difficulty. Instruct the billing person to invite patients with questions to step into a nearby office.

The billing person should be careful also to wish the patient a pleasant goodbye. An otherwise pleasant experience can be ruined by trouble about billing. The last 60 seconds of the visit can set the tone for the whole experience, no matter how nicely things went earlier.

". . . the doctor doesn't help the patient to know that he cares."

"One of the biggest causes of malpractice litigation is a breakdown in the doctor-patient relationship, trite as that may sound — and it hasn't been the patient's fault.

"People don't want to sue their doctors — they're driven to it.

"It's a case of inadequate involvement, not from the standpoint that the doctor doesn't care about the patient, but rather that the doctor doesn't help the patient to know that he cares."

It is doctors who are unavailable to answer patients' questions, or who speak only in medicalese; physicians with condescending attitudes; doctors who don't provide true informed consent and instead gloss over potential side-effects or adverse outcomes or fail to adequately explain "minor" procedures. When an untoward result occurs after such "uninformed" consent has been given, the patient can quickly leap to the conclusion that the doctor has erred.

— New York lawyer-physician Lee Goldsmith from the *American Medical News,* March 14, 1977

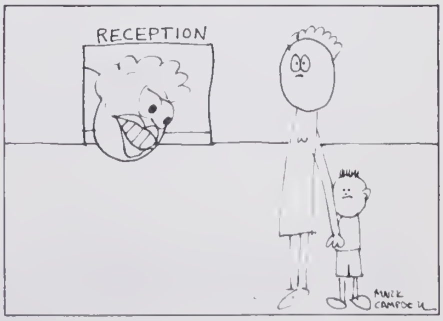
☐ ☐ *Unusual Circumstances.* When the doctor is late is there any way of making an explanation? A nurse or receptionist can tell people as they arrive that the doctor is behind schedule because of a special problem and express regret for the delay.

If newly arrived patients are admitted without waiting, is it clear there is a special situation? If a storm, power failure or unexpected event unbalances routine, patients should be advised of the situation.

Why not a suggestion box? A doctor who leaves note paper and invitation to submit ideas might be surprised at reactions which develop.

Encourage staff members to make their own suggestions about how patients' visits can be more pleasant. The ideal situation is to find procedures which take little effort but make patients much happier.

The doctor who really wants to go out on a limb might have fun swinging there. She/he might be pleased or instructed by supplying rating sheets to each patient with a request for reactions. Restaurants and motels do this, and it is certain management there gets feedback which is helpful.



We can do a better job with the public

Doctor Hamburger

By Joel I. Hamburger, MD Southfield

Too often physicians feel their leaders lack initiative in pursuing thoughtful and innovative solutions to problems. It seems as if our leaders only react to situations after they have deteriorated to the crisis point and after even the least of us can see that changes are coming. As a result those changes are made by others and we can only react when the time to act has long passed.

Let us consider some problems physicians are facing.

Biggest problem: Image

As I see it, the foremost problem today is a deterioration of our public image from dedicated public servant to busy businessman, prime example of conspicuous consumption, and, worse yet, rip-off artist par excellence, waxing fat at the public trough of Medicare, Medicaid and Blue Shield.

Of course, only a small portion of physicians are guilty of the more serious abuses. They are the rascals who deserve boiling in oil. Most physicians today are much like those of previous generations (except we have a better chance of doing something to help our patients). In fact, it is still true that the average person holds private physicians in high regard.

It is a mistake to think the escalating cost of medical care is the primary impetus for socialized medicine. The cost of many other goods and services has escalated as rapidly or more so, and there has not been the corresponding improvement in quality that has occurred in medical care. Yet we do not hear any serious cry for socializing the auto industry, the Teamsters, or the oil companies. Many American families spend more for cars, alcoholic beverages and smoking than for health care.

It is not the cost of health care that is the problem. The public attitude has turned against us, and attitudes are a matter of public relations. We can do a better job. For example:

1. Why is the AMA the biggest contributor to campaign funds? This buys us no friends in Congress, but buys us a terrible image. Why not spend this money producing literature for distribution by our best public relations people, we physicians? Why shouldn't every physician's office be a public relations center for the medical profession?

2. Why does the public learn of Medicaid fraud from TV and newspapers? Physicians in every community know who the crooks are. We say we police ourselves, but it is not true. We look aside when we see obvious examples of abuse. Our medical societies respond to complaints, but perhaps we should be more aggressive in making the public aware we are willing to review such complaints. Getting rid of the bad apples is essential to our good name.

3. Organized medicine stands solidly against mandatory consultations prior to elective surgery. Why? We say they aren't necessary because there is no significant amount of unnecessary surgery being performed. If our position is correct, what do we have to fear? We should be for mandatory consultations to prove to the bureaucrats unnecessary surgery is a false charge.

What is wrong with mandatory consultation prior to any elective hospitalization? That is where the big expenses are. There is an endocrinologist in our area who routinely hospitalizes patients for 10-day diagnostic workups that could be done just as well without hospitalization. Who questions his judgment? There is little doubt that the same thing happens in other medical specialties.

Current utilization review is a farce. I pass you, and you pass me, and the paper mill is satisfied while the public pays the bills. To be effective, utilization review must be done by physicians independent of hospital politics.

Can't deny abuse

We object to the questioning of our integrity and professional capability. We maintain that medicine is not an absolute science and there is room for honest difference of opinion.

But physicians, perhaps we protest too much. If we choose to deny abuse exists and instead affirm that we have the best possible system, only the most naive can believe the public will leave us alone. The question is not whether there are going to be changes, but rather who will institute them.

If our leaders will lead aggressively, we can still set ground rules for the changes that are going to take place. If not, and this is more likely, the rules will be made by those jolly good fellows who gave us our Medicaid guidelines. Then we can react and complain. We will be able to say with justification that we were right all the time. Government meddling into medical care only made it worse, just as we said would happen.

But we will be to blame, for we are the only ones who know how to make it better, and we don't.

Doctor Hamburger is past president of the Oakland County Medical Society.

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Here are some important facts you should know about PUREPAC generics

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*Copies of this study and PUREPAC's annual report are available upon request.

Meetings

(See also listing of Category I programs on page 277)

May 24-27 – Annual Meeting, Michigan Public Health Association, Park Place Motor Inn, Traverse City, Michigan, contact: MPHA 517/484-3044 or James K. Edmunds, 313/577-1400.

May 25-28 – Annual Conference, Association for the Care of Children in Hospitals, Hyatt Regency Dearborn, contact: Mary Frances Podolak, RN, Childrens Hospital of Michigan, 3901 Beaubien Boulevard, Detroit, 48201.

May 26-27 – Annual Gull Lake Conference, sponsored by MSMS Maternal and Perinatal Health Committee, MSU Conference Center, Gull Lake near Kalamazoo, contact: Helen Schulte, MSMS headquarters.

June 13-17 – Speech, Language and Hearing Problems of Older Persons: Identification and Management, Ann Arbor, contact: Dorothy H. Coons, Director of Cont. Ed., The Institute of Gerontology, The University of Michigan-Wayne State University, 520 East Liberty, Ann Arbor, Michigan 48109.

June 18-22 – AMA Annual Convention, San Francisco, contact: Warren Tryloff, MSMS Director.

July 10-13 – "A Sub-System Within the Health Care Delivery System," sponsored by Continuing Education, School of Public Health, University of Michigan, contact: Anna B. Brown, PhD, Director of Continuing Education, 3550 School of Public Health I, The University of Michigan, 109 S. Observatory Street, Ann Arbor, 48109.

July 11-22 – Biology of Aging, Ann Arbor, contact: Dorothy H. Coons, Director of Cont. Ed., The Institute of Gerontology, The University of Michigan-Wayne State University, 520 East Liberty, Ann Arbor, 48109.

July 18-21 – Medical Office Management Institutes (MOMI), sponsored by Conomikes Associates, Inc., Hospitality Motor Inn, Lansing, contact: Conomikes Associates, Inc., 4270 Promenade Way, Suite 122, Marina del Rey, CA, (213) 823-4661 or call (800) 421-6512.

July 22-24 – MSMS Council, Deer Lake, Boyne Falls, Michigan, contact: Warren Tryloff, MSMS Director.

July 24-29 – "Supervision in the Health Field: Theory, Process, Practice," sponsored by Continuing Education, School of Public Health, University of Michigan, contact: Anna B. Brown, PhD, Director of Continuing Education, 3550 School of Public Health I, The University of Michigan, 109 S. Observatory Street, Ann Arbor, 48109.

August 6-10 – Annual Convention and Scientific Assembly of the Michigan Academy of Family Physicians, Sugar Loaf Mountain, contact: Rita Feldkamp, MAFP executive secretary, 933 Wing St., Plymouth 48170.

August 7-12 – "Problems in Planning and Evaluation," sponsored by Continuing Education, School of Public Health, University of Michigan, contact: Anna B. Brown, PhD, Director of Continuing Education, 3550 School of Public Health I, The University of Michigan, 109 S. Observatory Street, Ann Arbor, 48109.

September 5 – MSMS/INTRAV Around-the-World Adventure, contact: Marce Ireland, MSMS headquarters.

September 7 – MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director.

September 12 – MSMS/INTRAV Orient Adventure, contact: Marce Ireland, MSMS headquarters.

September 17 – Michigan Society of Pathologists September Seminar, "Renal Disease, " St. John Hospital, Detroit, Michigan, contact: Dr. John F. Dunkel, Department of Pathology, MSU, East Lansing, 48823.

November 2 – MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director.

November 8-10 – MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Herb Auer, MSMS headquarters.

December 14 – MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director.

AMA sponsoring hospital staff meetings soon

Michigan physicians can obtain information from the AMA about five two-day Hospital Medical Staff Leadership Workshops to be conducted by the AMA this summer and fall across the nation.

Hospital medical staff leaders, according to the AMA, "will get assistance with critical challenges in decision-making, communications and relationship problems."

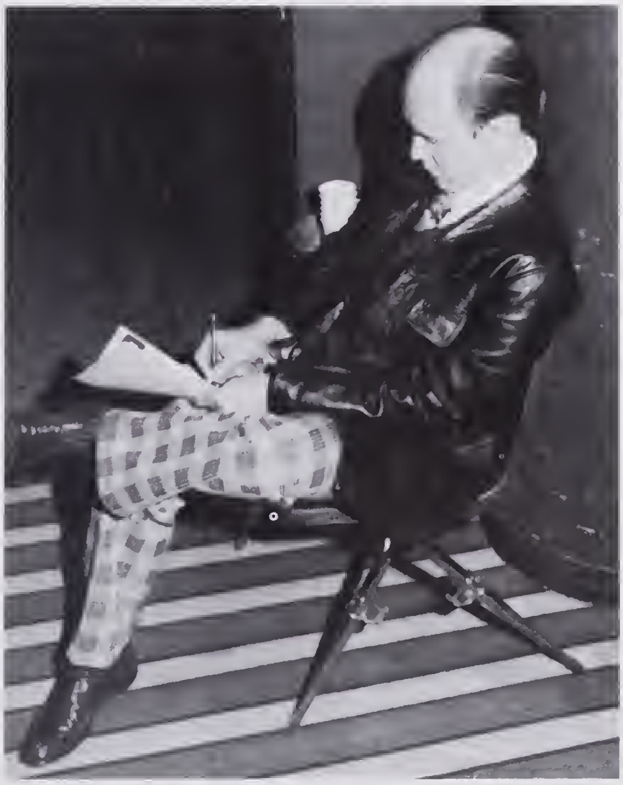
The workshop will deal with JCAH standards, roles and responsibilities, medical risk management, patient care responsibilities, house staff leadership, and other related topics. The programs are scheduled for Atlanta, Columbus, Philadelphia, Chicago and Dallas.

The workshops will carry Category I CME credits.

For details write to AMA, Department of Hospitals and Health Facilities, 535 N. Dearborn, Chicago 60610.

Part of crowd of 900 physicians, medical students, nurses and other interested persons who attended the 1977 Michigan Conference on Maternal and Perinatal Health March 30-31 in Kalamazoo.

Hermann A. Ziel, Jr., MD, Lansing, chief, Michigan Bureau of Health Facilities, center, and Lee B. Stevenson, MD, Detroit, chairman, MSMS Committee on Maternal and Perinatal Health, right, chatted during a break.



John V. Hartline, MD, Kalamazoo, conference chairman, takes notes.

Grand Haven obstetrician M. Gary Robertson, MD, attended the conference.

1977 MSMS Maternal Health Conference — Photos

Will you please tell Michigan physicians how your medical school will be affected by the new Health Professions Educational Assistance Act of 1976? *Michigan Medicine* put that question to the deans of the state's three medical schools recently. Replying below are Wayne State University and The University of Michigan. (Michigan State University did not send an article by press time.) The new act authorizes continued capitation grants for medical schools, with national priorities imposed to require a set percentage of residencies in primary care. The law limits the designation of primary care to internal medicine, family practice and general pediatrics.

Medical College

WSU needs more funds to return to par

Robert D. Coye, MD
Dean, WSU School of Medicine

At this stage of the game, it is difficult to evaluate the impact which the new Health Professions Education Assistance Act might have on our operations. The new legislation is essentially an extension of the previous Health Manpower Act which began in 1971, which was introduced as an incentive to expand medical education throughout the United States.

The funds received from the original legislation constituted an integral part of the funding which enabled our school of medicine to double its enrollment. With the expanded enrollment it is critical that we continue to receive significant monies under the new Health Professions Educational Assistance Act. Otherwise, our teaching program will be jeopardized. For us, the continuing legislation does not enable us to undertake new programs, but rather is required to support the programs introduced during the expansion period.

The prevailing thought is that the new legislation will provide funding next year at approximately the same level as that received in the current year. It should be noted that current funding is only at a level of approximately 55% of the initial level of funding. Consequently, we feel that it is imperative that we receive expanded funds in future years if we are to fulfill all of the commitments made during the expansion of enrollment period.

U-M 'anticipating, apprehensive'

By John A. Gronvall, MD
Dean, U-M Medical School

The Health Professions Educational Assistance Act of 1976 (P.L. 94-484), signed by President Gerald Ford on October 12, 1976, establishes the legislative basis for federal educational support to medical schools through 1980. The new act replaces the Comprehensive Health Manpower Training Act of 1971, a law which actually expired in the summer of 1974.

Major Provisions of the New Law

The overriding purpose of the new law is to produce more primary care practitioners and improve health services in manpower shortage areas. Here are some of the major ways in which the act will impact on the University of Michigan Medical School.

Student assistance will be provided in several ways. The present student loan and loan repayment programs continue, but are made more restrictive, with higher interest rates. The National Health Service Corps Scholarship Program, which requires service after graduation, is expanded through a greatly increased appropriation. New programs of insured loans and first year scholarships for students of exceptional need are established.

Core support to the medical schools for their basic educational programs (the "capitation" grant) will be continued, but with new requirements.

Schools need not expand enrollment, but must maintain previous enrollment levels. The law will, however, require that residency programs affiliated with medical schools have an increasing percentage of positions in primary care programs.

Thirty-five percent of first year positions must be in primary care as of July 15, 1977, with increases to 40% the following year and to 50% in July, 1979.

The law, therefore, establishes for the first time a direct federal control over types of residency positions. A more controversial provision requires all schools accept for transfer U.S. citizens attending foreign medical schools, and who have completed Part I of the National Board Examination.

The new law includes restrictions to significantly reduce immigration of foreign medical graduates into the United States.

U of M Medical School Plans

Even before the new law was passed, the U of M Medical School had reached a plateau in student enrollment. Our two MD programs ("regular" four-year and six-year "Inteflex" curricula) together enroll 237 new students each year. This enrollment will be continued.

Major impact will be felt in residency education at Michigan. Our plan to establish a Department of Family Practice and initiate a residency program in family practice in the summer of 1978 will contribute to an increased proportion of residency training in primary care. We anticipate some federal grant funds may be available to assist this new department, and might also support improved and expanded programs in general internal medicine and general pediatrics.

We have significant concern about how student aid provisions will affect both the characteristics of students entering medical school and career plans of students.

In general, the new law will significantly increase interest rates on medical students' loan funds. This factor, coupled with general inflation and increasing tuition levels, may again make medicine a profession which largely excludes economically disadvantaged students.

Although total funds available for student support will not likely decline, the direction of this funding program (phasing out scholarships except for those with obligatory service requirements, and replacing federal loan funds with commercial loan funds at higher interest rates) is a worrisome trend.

While Congress, through this bill, has announced a goal of increasing the number of primary care practitioners, the larger debt load carried by students in the future may, in fact, provide an incentive for more students to enter subspecialty practice where earnings will be higher.

Anticipated funding levels

The new act contains *authorizations* which could expand potential federal support to medical schools. However, actual *appropriations* to implement the new act remain a matter of speculation at present. The impact of the Carter administration budget proposals, and Congress' appropriations cannot yet be predicted.

Actual federal support for basic medical school operations has declined significantly in the past two years.

The U of M Medical School received approximately $1.7 million of capitation support during 1974-75. In 1975-76, this was reduced to about $1.3 million, and during the current year (1976-77) support was further reduced to $813,000. Over the two-year period, therefore, this medical school has suffered a reduction of $900,000 in basic educational support from federal sources.

Optimistic projections would be for a return of support at this medical school to a level of approximately $1.2 million per year during 1978-79. Our support during the coming year (1977-78) will likely continue at about the level of present year support.

Foreign medical student provisions

The most controversial element in the new act will require every medical school to reserve an "equitable number" of positions to accept by transfer US citizens who have attended foreign medical schools for at least two years and successfully passed Part I of the National Board Examination. The HEW secretary will identify such individuals, and establish the number of positions each school must accept. Although the schools need not enroll any student who does not meet general entrance requirements, schools *cannot* exclude students based on academic or residence qualifications. The act, therefore, establishes by federal authority the presumption that every such student who has completed two years in any medical school in the world, and has passed Part I of the National Board Examination, is academically qualified to enter any one of the US medical schools. State supported schools will be prohibited from taking into account whether the student is a resident of the state.

It is impossible to predict how many such transfer students will be mandated under the act. Potential exists for a sufficiently large pool of such students to require every medical school to enroll upwards of 25 students per year.

Active consideration is now being given by both individual universities and educational organizations to work for repeal of this section of the act. Regardless of the outcome, inclusion of this provision in the act signals a previously unprecedented willingness of the federal government to adopt legislation about specific elements of medical school operations.

Summary

Since the general intent of the act is consistent with programmatic directions at the University of Michigan Medical School, we hope that federal support will be made available through the act for these changes. We look forward with a mixture of apprehension and anticipation to the unfolding of this new relationship, which places a large measure of control in the hands of the federal government.

Michigan State University's College of Human Medicine also was contacted to contribute to this issue, but at press time, had not submitted a report.

How Michigan med schools select students today

By C. R. Shelton
Special to Michigan Medicine

Perhaps the best advice you can give students wanting to increase their chances of getting into medical school is to tell them to consider alternate career objectives. That's according to Judith Krupka, PhD, Michigan State University College of Human Medicine, associate dean for admissions and student affairs.

Not that it is impossible to be accepted, she says, but with so few places available and so many applying, the pressures are great, particularly for students with no other objective in mind.

There are, of course, some things that help a student's chances of being accepted at the three Michigan medical colleges: (1) Being a Michigan resident, (2) Maintaining high marks in courses — particularly science and math, (3) Having a sincere desire to serve people, and (4) Being honest. Most of those are important considerations in the screening processes at MSU, U of M and Wayne, though none of them alone will assure the student a place.

There are a few things that probably will keep a student out, however. Low scores on the Medical College Admissions Test, evidence of dishonesty, failure at another medical school, and, if foreign born, being without a resident visa, will almost always stop the approval process.

Admission policies at the three colleges are similar, but do differ as the following brief review indicates.

MSU policies

At Michigan State University College of Human Medicine, about 3,000 applications are received yearly. Usually 135 new students are accepted.

Applications are reviewed and scored by members of a 16-person admissions committee (made up of faculty and students who have completed a three-day interview workshop) with special attention given to grade point average, number of hours per week the student worked, credit load carried, biographical information, if the student is from a rural or inner city background, and whether the student is interested in practicing medicine where patients presently are underserved.

On the basis of that scoring, about 300 applicants are tapped for interviews — of that group approximately 270 are Michigan residents. Two structured, quantitative interviews follow.

Following the interviews, reports are written by the two interviewers who give a numerical score to the applicant. That score plus the score on the supplementary application are combined, and if the total is above a certain point, the student is accepted.

Dr. Krupka describes a typical MSU medical student as one who can carry through with work without being told explicitly what to do, is sensitive to other people, and can truly be helpful to others.

At the East Lansing medical college, where the thrust is to train highly skilled physicians with a humanistic approach to medicine, it has not been necessary to establish separate minority or female policies because the college has a larger pool of minorities and women than is the case nationally.

WSU policies

At Wayne State University School of Medicine, where Joseph Dogariu is counselor of admissions, about 256 students are accepted each year from an applicant pool of around 2,600.

Applications are screened first on their MCAT scores with special attention given to grade point average and the biographical section. Ratings are made on the basis of grades achieved in science, math, verbal ability—which is more or less vocabulary—and general information about the applicant.

Applicants who pass the initial screening are asked for secondary information. That information is carefully reviewed by the Admissions Committee and if the applicant passes the second screening, he or she is asked to an interview.

The interview is conducted by a member of the 14-member Admissions Committee and results are presented, by the interviewer, to the full committee for discussion.

The committee votes Olympic-style, with the highest and the lowest scores dropped. Then the remaining 12 scores are averaged. If the committee rating is above a certain number, the student is offered a place and has two weeks to accept.

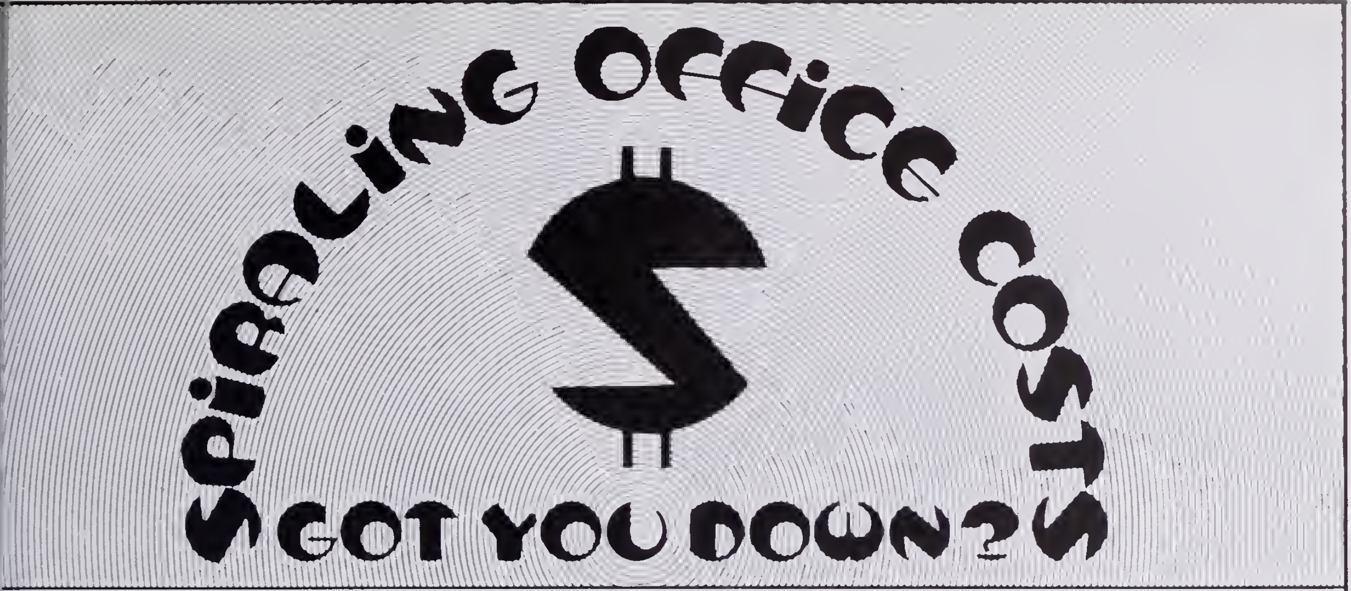
Wayne State University School of Medicine is committed to attracting minority students, and is said to have the highest minority enrollment in the state. About 27 minority freshmen are admitted yearly, as are approximately 50 women. Ninety percent of the students are Michigan residents.

A special summer training program is offered to approximately 10 minority students the school feels could be accepted into the program following intensive preparation.

U of M policies

The University of Michigan Medical School received approximately 4,000 applications for enrollment this year as opposed to about 4,500 last year. Approximately 200 new students are admitted there yearly,

(Continued on page 262)



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Physician responsibility in multiphasic testing

The following is another in the series of recent opinions on medical-legal problems of general interest provided by MSMS Legal Counsel for MSMS members. It has been adopted somewhat from the original opinion. This material is intended only to inform and should not be used to resolve legal problems.

Responding to inquiries on physician responsibility for the use of unsolicited multiphasic testing results, MSMS's legal counsel has replied:

"We are told that hospitals and large employers doing routine screening examinations are forwarding reports of those examinations, generally in the form of computer printouts, to physicians. This may be acceptable when the doctor in fact recognizes the subject as a patient. Problems can develop when the physician does not recognize the subject at all or when the physician does not regard the subject as a current patient.

"In those situations where the physician has never seen the patient, liability is not a great concern. This may happen where the individual (who apparently gave the doctor's name to the employer) regards the physician as the doctor he would see. Receipt of the report does not establish the physician-patient relationship, and an ensuing duty upon the physician. However, even in those instances, the physician is not immune from legal attack.

"If the individual has been a patient, the physician is placed in an untenable position. If the screening test discloses facts which warrant further inquiry, it may be claimed that the physician has the duty to contact the patient. This is an imposition and is impractical.

"As to unsolicited reports on individuals who are not current patients, this response is suggested:

> 'We herewith return your report pertaining to ________. This person is not a present patient of this office. No arrangement has been made for our review of this report, and we have no authority to proceed.
>
> 'Please contact promptly. He should be instructed to contact us directly if he wishes us to obtain a copy of this report so that we may attend to his medical care. In the future, if you examine individuals who state that they are patients of this office, and if those persons wish us to review their test results, please have them contact us directly for this purpose. We will then request the report from you and will furnish necessary authorization.'

"As to patients who are recognized as past patients but who are not under active treatment, it is not inappropriate to contact those persons and ask that they arrange for an appointment if you are to review test results. You can explain that the physician cannot render useful advice without such examination as good medical practice requires.

MED SCHOOLS/*Continued*

and more than 80 percent of them are Michigan residents.

Colin Campbell, MD, associate dean for student affairs, says that initial screening of applicants is done by computer with equal importance placed on the student's undergraduate grade point average and MCAT scores.

Michigan residents in the top group automatically are asked to complete the University's application. Middle and lower Michigan groups and non-residents are reviewed by committee members and staff.

When the reviews are completed, over 1,000 hopefuls whom the school considers to be top candidates are asked to complete the University application, and meet other requirements. Then most are asked to an interview.

During the interview, the applicant is checked for motivation, maturity, ability to relate to others, and desire to be in medicine.

Four of the University's 16-member admissions committee then make a comprehensive deliberation of everything known about the applicant before final scoring begins. An Olympic-type scoring system is used by the Committee, scoring downward from 10, with admissions made from the top down.

Current classes at the University of Michigan Medical School are composed of about 10 percent minority members. The female ratio is approximately in proportion to the number who apply, or roughly one-fourth.

The school does not require that a certain number of students specialize in a particular area. Rather it makes an effort to help develop the total potential of the students so that they can succeed in any specialty.

During the past few years, more students have been selecting the primary care fields.

"Without being required to, students tend to select in those areas where society needs them the most," Doctor Campbell concludes.

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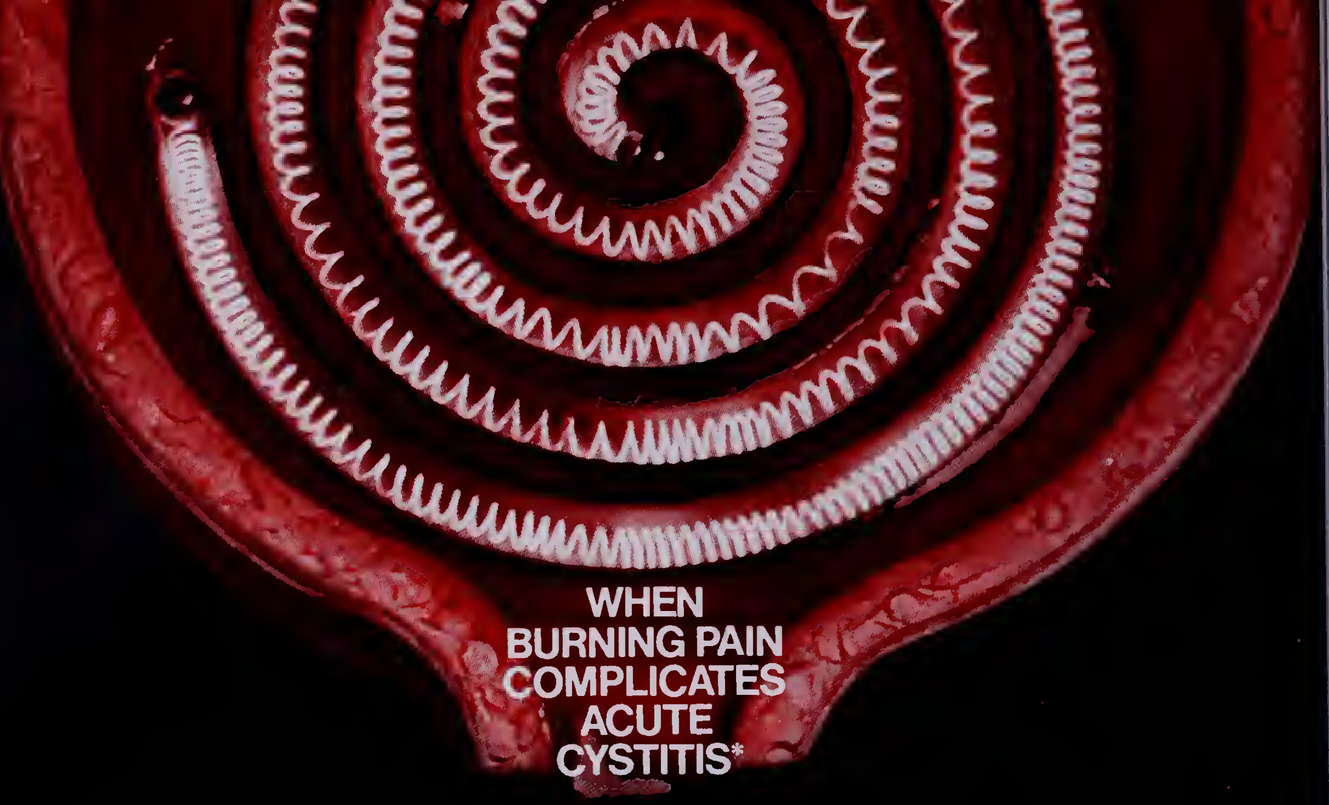

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Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides. Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis), *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

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* **Indications:** When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

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Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium® (triamterene, SK&F Co.), and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

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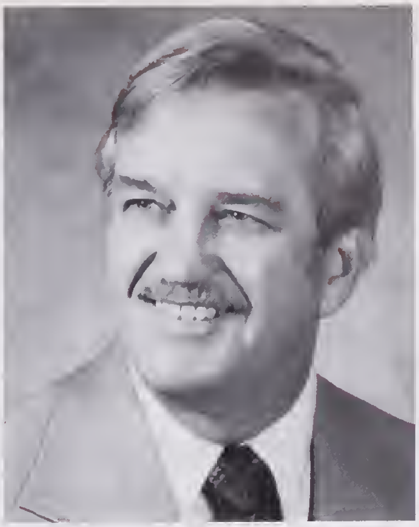

Doctor Hayes

Defensive medicine the incorrect solution

By Louis F. Hayes, MD
Detroit

Bloodletting to balance body humours was one of many ancient practices whose promises to cure disease were void.

Today, the practicing physician is more sophisticated. He can tell patients that pathological and radiological procedures will be relatively painless and diagnostically helpful, because he knows so.

But too many physicians today order too many laboratory tests and X-rays.

Some of them reason that such tests are required protection against professional liability exposure — that they must practice "defensive medicine." That rationale is questionable, and its economic impact is significant.

It cannot be denied the professional liability crisis has left many physicians with few alternatives to "going bare" or packing up their shingles and heading someplace where they can better afford to practice.

Defensive medicine ineffective

But the practice of "defensive medicine" is not the answer. It is, in fact, one of the most ineffective solutions to the problem.

Why the dramatic increase in alleged medical malpractice? We know the cause is not a sudden surge of negligence, failure to diagnose, poor results, or complications in treatment. To whatever extent they exist, they are not new problems.

Some attorneys would have you believe patients sue doctors more now, because there is more negligence — not because of hungry lawyers. Other attorneys say increased litigation is due primarily to deteriorating physician-patient relationships. This argument appears more reasonable.

Professor Jon Waltz, lecturer in medical jurisprudence at Northwestern University, contends the primary cause of malpractice suits is frequent breaching of patients' legitimate expectations. He says, "We no longer invariably revere the healer; occasionally we revile him. We think that the healers, while getting rich, are disregarding our most basic and valid expectations."

What has caused this strained doctor-patient relationship? Several factors tend to influence patient attitudes:

- In this age of "consumerism," people are highly conscious of and concerned about the quality of all goods and services they purchase. The term "patient" has taken on a much different connotation — that of "consumer of health care services."
- The psychological impact of television's fictional physician. He is fundamentally personable and personal; he is constantly available, day and night; he has an unrelenting desire to cure a specified illness; and he expresses no concern for fees and the patient's ability to pay them. All this marvelous humanity among the "TV docs" — particularly, the specialists — is a dramatic distortion of reality that is more readily recognized by doctors than laymen.
- Another negative influence is the patient's notion of personal economic gain. Any resourceful person or group can discover at least average figures on physician incomes — and many do before they sue.

More germane to the problem is the basic issue of "self-protection." Does voluminous testing really protect the physician against charges of negligence? Is volume preferable to specificity?

The answer to both questions seems to be "no." Recent data from the National Association of Insurance Commissioners "Malpractice Claims Survey" (covering 4,742 misadventures in procedures and diagnoses) suggests that "defensive medicine" is the most *ineffective* weapon a physician can use.

54% involved procedure

In 54 percent of the cases there were misadventures in procedure, bearing no relationship to diagnostic misadventure. Twenty-eight percent of the cases involved a combination of misadventures in both procedure and diagnosis. The primary diagnostic misadventure was *delay* in diagnosis (13 percent). Misdiagnosis, based on *improper interpretation* of test results, was the cause in 15 percent of the cases. In merely two percent of the

(Continued on page 268)

Doctor Hayes is group vice president of professional affairs, Blue Cross/ Blue Shield of Michigan.

Physicians must show compassion for SIDS victims' families

Doctor Smialek

By John E. Smialek, MD
Detroit

Many Michigan doctors are sadly in need of education regarding sudden infant death syndrome (SIDS, "crib death"). Consider the following circumstances:

An infant is found dead in his/her crib. The police or an ambulance are called, and the victim is rushed to the hospital where death is pronounced. The parents say that the baby had a slight cold but appeared all right before he/she was put to bed. Milk vomitus is present on the infant's face and on the bedding. The baby was sleeping face down, and face and chest are mottled and purple.

The sequence of events following such a death very often reveals a lack of understanding of current information on infant death.

Present medical knowledge recognizes sudden infant death syndrome as a natural, unpredictable, unexpected death occurring in apparently healthy infants. Nevertheless, despite continuing efforts at education of the medical community, parents in many Michigan counties are subjected to unnecessary interrogations, improper suspicions, and incorrect certification of their infant's death.

Some Criticisms

Several criticisms are evident on careful examination of infant death cases in Michigan.

First, in many jurisdictions police treat all infant deaths as possible homicides. In *actuality,* if the initial investigation does not provide evidence of such abuse, law enforcement personnel could limit their further investigation until the autopsy has been completed.

The lead for humanizing the approach to handling of sudden infant death should come from the medical community. The medical examiner as a liaison with law enforcement officers is a logical individual to provide the necessary education.

Second, some medical examiners mistakenly interpret vomitus at the opening of an infant's airway as evidence of asphyxiation by regurgitation of stomach contents. Such expulsion of food from the stomach occurs at the time of death and does not constitute the actual cause of death. Definite evidence of asphyxiation on foreign matter is the presence of foreign material in terminal bronchi and bronchioles with an early acute inflammatory response. This naturally implies the necessity of an au-

(Continued on page 270)

Doctor Smialek is deputy chief medical examiner for Wayne County.

DOCTOR HAYES/*Continued*

misadventures was the litigation attributed to inadequate diagnostic pursuit.

Also noteworthy: The (HEW) Secretary's Commission on Medical Malpractice indicates that only a small percentage of alleged patient injury is due to negligence. This contradicts still another popular misconception of the basic nature of malpractice.

It's incorrect solution

The above information suggests that practice of "defensive medicine" is like "putting the shoe on the wrong foot." Aside from being statistically unnecessary, it is the incorrect solution to the problem. Instead of addressing the key issue — the doctor-patient relationship — practice of "defensive medicine" accepts inevitability of litigation by preparing for it. It also has the effect of establishing an artificially inflated "standard of care."

Given the high incidence of patient misunderstanding, negative attitudes, and strong sense of consumer rights, it behooves the physician to deal with that part of the problem that is often underestimated — simple anger.

Because anger nearly always accompanies potential claims for medical liability, the physician must try to thwart it as early as possible. This means spending more time with the patient, informing him or her about the illness (or lack thereof), and leading the patient to reasonable expectations.

Dehumanization takes many forms in this technologically progressive age. Two of the most common are described with deliberate exaggeration — exsanguination and irradiation. Perhaps the physician ought to be thinking about their consequences and the dangerous, costly trend of overutilization.

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COMMENTARY/*Continued*

topsy. However, frequently death certificates are completed with the term asphyxiation due to regurgitation of vomitus, no autopsy, and the manner of death incorrectly labelled accident.

Many pathologists appear reluctant to utilize the term sudden infant death syndrome despite the lack of positive findings at autopsy. As a result, irrelevant terms such as pulmonary edema, medullary failure, viral pneumonia, or pneumonitis appear on death certificates.

Detrimental Effects

The detrimental effect is two-fold. Firstly, accurate figures of the incidence of sudden infant death syndrome are unobtainable. Secondly, parents are denied the benefits of counselling by public health departments and support of parent groups.

Since post-mortem examinations are necessary to establish the diagnosis of SIDS, an effective mechanism to provide these is presently being provided through State Act 350.[1]

This legislation allows state funds to be used as payment for local autopsies when requested by the parents. This requires the cooperation of the medical examiner to inform the parents of the availability of autopsy examination. The examiner also should advise them of the importance of a post mortem examination, recognizing that answers to parents' present and future questions require this information. The past excuses for failure of autopsy examination in such cases which included the lack of county funds for examination of death not involving prosecution should now be obsolete.

We, as physicians, have a responsibility to understand the characteristics of one of the most prevalent causes of infant death in this country responsible for an estimated 350 infant deaths each year in Michigan. Until we are able to provide answers to the cause(s) and prevention of sudden infant death syndrome, we must extend our compassionate, humane attention to the families of SIDS victims. Unwarranted suspicions and failure to provide support to these individuals reflect our continuing lack of understanding of one of today's major pediatric health problems.

1. Taylor, J. R.: Meeting the Many Problems of an Unexpected Infant Death. *Michigan Medicine,* April 1976, pp 205-206.

MSGS
Michigan Society of General Surgeons

PURPOSE

To give General Surgeons a socio-economic organization designed to aid them in their dealings with governmental and other third parties.

FUNCTIONS

To protect the public interest.
To protect the surgeon from intervention in performance of his professional duties.
To gather information regarding General Surgery, to inform ourselves and to provide a solid factual basis for dealings with others.
To join with similar organizations of other specialties to promote our common aims.
To make available to interested people or organizations, opinions and recommendations which could be helpful to planners of present or future programs where they relate to surgery.
To strive toward standardization and simplification of the paper work involved in the practice of surgery.

QUALIFICATIONS FOR MEMBERSHIP

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For further information write Glenn E. Moore, MD, 1915 Lincoln Dr., Flint, Mich. 48503, Secretary-Treasurer.

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How it works: the medical examiner system

By J. H. Ahronheim, MD Jackson

Benefits derived from the change to the medical examiners system from the old county coroner's system are tri-fold, as seen by this writer:

1. The traditional prerogatives of the licensed physician of establishing cause of death, of pronouncing death and of signing the death certificate have been taken out of the hands of laymen and returned to rightful holders.

2. Medical investigation of cases of unexplained or violent death is left no more to electoral chance but now lies with professional men who are appointed on a relatively permanent basis.

3. The past four years have been a training period to the participants in the medical examiners system giving them the opportunity to acquaint themselves with the various issues and to correct whatever weaknesses may have come to the surface during these four years.

Our experiences in Jackson County amplify these views.

The system of medical examiners went into effect on January 1, 1973 in Jackson County, as it did in all counties in Michigan which had functioned under the former coroner system.

The Chief ME in the smaller counties is a practicing physician, often the part-time or full-time health officer of the county. The autopsies, as a rule, are performed by general pathologists, who have acquired their forensic knowledge by experience rather than formal training.

The Chief ME of Jackson County, F. I. VanWagnen, MD, is a practicing

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Doctor Ahronheim serves with the office of the medical examiner for Jackson County.

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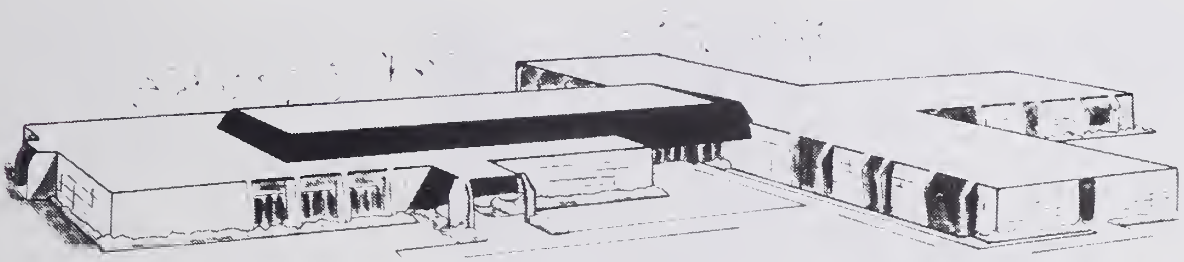

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Number of Cases and Autopsy Percentages in Jackson County As Investigated by Coroners and by Medical Examiners

Coroners Cases				Medical Examiners Cases			
Year	Number	Autopsies and Percentages		Year	Number	Autopsies and Percentages	
1969	395	110	28 %	1973	232	112	48%
1970	397	98	24.6%	1974	221	102	46%
1971	263	86	32.7%	1975	228	104	45%
1972	297	112	37.7%	1976	254	122	48%
Total	1352	406	30 %		935	440	47.3%

Doctor Ahronheim

physician who is also a part-time health officer. The 21 deputy ME's are likewise either physicians in private practice or staff emergency rooms of the local hospitals. The autopsies are performed by the writer, a general pathologist.

The figures presented in this table could be viewed in different lights. Some might maintain coroners used more discretion in ordering postmortem examinations, thus saving the county considerable amounts of money. Others might emphasize the low percentage of autopsies ordered by the coroners proves many cases of unexplained death were incorrectly diagnosed and cases of foul play may have been missed. Some might point out the drop from 1,352 cases investigated by the coroners to 935 cases investigated by the ME's (down to 69.2%) might be interpreted as meaning that more discretion was used by physicians before designating a case to jurisdiction of the ME. They might also point out that the number of au-

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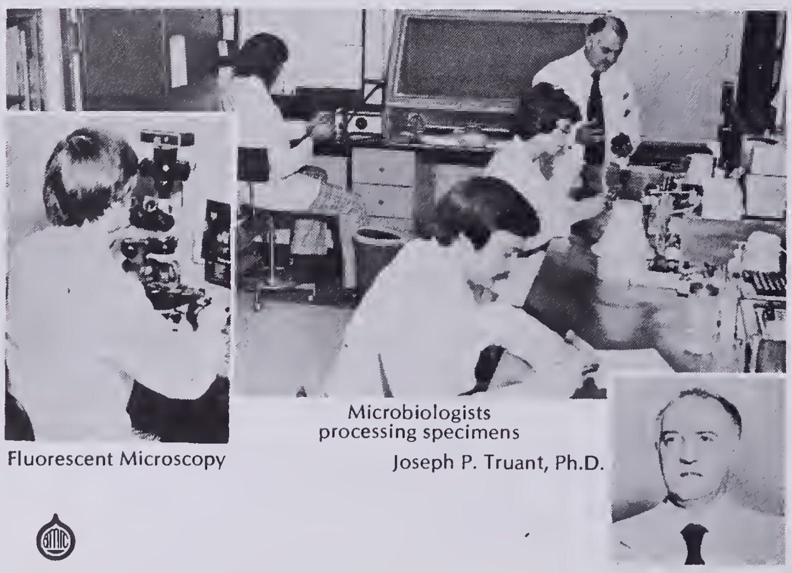

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topsies ordered under the two systems is misleading if percentages are used — more than 50% under the ME than the coroners system.

The increase from 406 to 440 cases (up 10.8%) is less spectacular. This comparatively small increase, they might say, could thus be attributed to cases which coroners supposedly missed, while the ME's are more cautious in their selection. In fairness to the lay coroners it must be stated that these statistics can hardly be considered a criterion of poor performance on their part, nor of excellent performance on the physicians' part.

In retrospect, it becomes evident that the changeover has not immediately eliminated whatever may have been wrong with the investigation of unexplained or suspicious deaths. It was inevitable that the ME system has its weaknesses. Lack of experience of newly appointed deputies and considerable turnover has led to errors in judgment, particularly in ordering or not ordering post mortem examinations. It seems that the majority of unnecessary autopsies have resulted from a number of erroneous impressions held by the inexperienced.

New Noninvasive Clinic open at U-M Med Center

The University of Michigan has a new Noninvasive Vascular Diagnostic Clinic located within the Medical Center. Its director is William S. Gross, M.D., assistant professor of surgery.

The studies available provide objective assessment of blood flow and aid the physician in planning future therapy for the patients.

The vascular laboratory provides an inexpensive and safe means of screening patients suspected of having vascular disease.

Further information is available from Doctor Gross, B 3957 C.F.O.B., University Hospital, Ann Arbor, Michigan 48109.

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Health care system becoming public utility

By James Hickey Chicago

Regulatory influences have virtually converted today's health care delivery system into a complex network which is similar in many respects to the public utility industry. It is important for health care regulators to recognize these similarities and consider adaptation of the regulatory concepts which have served the public utility industry fairly for decades. Especially worthy of consideration is the basic responsibility of public utility regulatory agencies for the financial stability of each member of the system.

Today, overwhelming and inexorable forces are being brought to bear upon hospitals to improve the quality of care while holding costs down. Throughout the nation, hospitals are subjected to influences originating with groups who often work at cross-purposes. Each group is oriented towards a small segment of hospital operations, and it is this restricted orientation which now undermines the financial viability of the health care system.

On the one hand, there are rate setting commissions, third party payers, and other organizations which scrutinize patient care costs with increasingly critical eyes, confronting any hospital that violates pre-set fiscal limitations. On the other hand are the peer review groups, accreditation and licensing bodies in boundless number, plus a plethora of medical specialty organizations, all insisting on a maximum of that intangible commodity, "quality health care," without respect for the cost implications of their demands.

Mr. Hickey

How they are similar

Through extensive experience in both areas, we view these developments as particularly significant; a glaring signal that, more and more, the health service delivery system is becoming functionally and administratively similar to the public utility industry. Specifically, public utilities and health services today share four major similarities:

1. Both provide essential public services.
2. Both have controlled access to an operating franchise.
3. Both are subject to external control by regulatory agencies.
4. Both are subject to significant fiscal controls by external organizations.

With these basic similarities in mind, it is somewhat enigmatic that utilities, by and large, are today not only viable, but thriving; whereas many hospitals are staggering under the weight of external regulatory pressures. This "mystery" rapidly dissolves, however, with an inspection of the three essential *contrasts* that differentiate utilities from health care services.

First, hospitals provide multiple services, making the delivery system relatively complex, while public utilities provide a simple service.

Second, hospitals do not have specific geographic franchise areas. Rather, the tendency is to give franchise to the services offered. Public utilities are granted specific geographic franchise areas.

Third, regulatory agencies have no mandate or responsibility to assure the financial health of the individual constituents of the health care delivery system. By legal precedent, public utility regulators are required to balance service needs of utility customers with the financial needs of the utilities themselves.

Given the strong similarities shared by these two industries, it is interesting to speculate as to why their respective regulatory authorities have produced such divergent philosophies concerning their role in assuring the present and future financial viability of the industries.

The responsibility of public utility regulators is, simply stated, to assure the quality of service to rate-payers *and to approve rates which will maintain an adequate return to utility capital.* In stark disparity, regulators of the health care delivery system place an unbalanced emphasis upon quality, and generally disregard the effects of costs occasioned by improved quality or availability of service. Even more severe is the absence of responsibility on the part of any health care regulator, or group of regulators, to oversee the financial health of hospitals and approve corrective measures where warranted. Irrespective of a hospital's status as proprietary or not-for-profit, the need for adequate capital replenishment exists; blithe disregard of the problem can only result in a future crisis which individual hospitals will be unable to resolve.

Conclusion

It is clear that, either inadvertently or by design, regulators are transforming the health care delivery system into an intricate public utility network. Perhaps now is the time for health care regulators to look to the principles of public utility regulation as a model and adopt the concept that those who mandate the structure of the delivery system must also stand accountable for its continuing financial vitality.

The author is manager, ALEXANDER GRANT & COMPANY, accounting firm, Chicago.

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BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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Category I Courses

Michigan Medicine *each month will carry a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of the new Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing will indicate a contact person, so the physician can obtain details. The list will be expanded as courses are developed by accredited sponsors. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.*

The following have been accredited by MSMS Commission on Continuing Medical Education:

Organizations:

Ann Arbor Psychiatric Association
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Society of Anesthesiologists
University of Michigan School of Public Health

Hospitals:

Alma-Gratiot Community Hospitals, Alma
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med.Center, PC/Little Traverse Hospital, Petoskey
Butterworth Hospital, Grand Rapids
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Community Health Center of Branch County, Coldwater
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Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Henry Ford Hospital, Detroit
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
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Kalamazoo State Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital), Muskegon
Marquette General Hospital
McLaren General Hospital, Flint
Mercy Hospital, Port Huron
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Oakland Medical Center, Pontiac
Oakwood Hospital, Dearborn
Pontiac General Hospital, Pontiac
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Edward Sparrow Hospital, Lansing
Traverse City State Hospital, Traverse City
V. A. Hospital, Battle Creek
Wayne County Psychiatric Hospital, Eloise
West Shore Hospital, Manistee
Ypsilanti State Hospital, Ypsilanti

Date: May 14 — 23rd Annual Alumni Clinic Day, and Second Annual Ruedemann Memorial Lecture, a pediatric ophthalmology symposium. Location: Michigan Inn, Southfield. **Sponsor:** Kresge Eye Institute of Wayne State University. **For:** Pediatricians, ophthalmologists. **Cost:** $25. **Contact:** John D. Baker, MD, Kresge Eye Institute, 3994 John R, Detroit 48021. **Approved for:** 7 hours of Category I credit.

Date: May 16-20, Advances in Internal Medicine. Location: Towsley Center, U of M Medical Center. **Sponsor:** U of M Office of Intramural Education. **For:** Internists. **Cost:** $225. **Contact:** U of M Office of Intramural Education*. **Approved for:** 35 hours of Category I Credit.

Date: May 17, Cancer of the Cervix. Location: Wayne County Medical Society, 1010 Antietam, Detroit. **Sponsor:** WSU Department of Oncology. **Co-sponsor:** Detroit Cancer Club. **For:** All interested physicians. **Cost:** $20. **Contact:** Dorothy Bewley, Dept. of Oncology, Wayne State University, 4160 John R., Detroit 48201. **Approved for:** 2½ hours of Category I Credit.

Date: May 17, "Michigan Primary Care Preceptorship Program" Workshop. Location: Mariott Inn, Ann Arbor. **Sponsor:** Michigan State University College of Human Medicine. **For:** Primary Care physicians. **Cost:** None. **Contact:** Lynda Farquahar (517) 353-5440. **Approved For:** 4 hours of Category I Credit.

Date: May 18, Pediatric Dermatology Seminar. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** Pediatricians, family practitioners, dermatologists. **Cost:** $50. **Contact:** Office of CME, St. John Hospital, Detroit, (313) 881-8200, ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: May 19, Workshop on the Management of Acute Poisoning and Overdose. Location: Midway Motor Lodge and Hoffman House, Grand Rapids. **Sponsor:** American Academy of Clinical Toxicology, American Association of Poison Control Centers, American College of Emergency Physicians, Western Michigan Poison Center, West Michigan Emergency Medical Services, Inc., and Blodgett Memorial Medical Center. **For:** All specialties. **Cost:** $30. **Contact:** Western Michigan Poison Center, 1840 Wealthy St., SE, Grand Rapids, 49506. **Approved for:** 8 hours of Category I credit.

Date: May 21; June 4, and June 11, Workshop in Indirect Ophthalmoscopy and Peripheral Retinal Anatomy and Pathology. Location: Kresge Eye Institute, 3994 John R, Detroit, 48201. **Sponsor:** Kresge Eye Institute. **For:** Ophthalmologists. **Cost:** $20. **Contact:** Harold Weiss, MD, Course Director, Kresge Eye Institute, 3994 John R, Detroit, 48201. **Approved for:** 4 hours of Category I credit.

Date: May 21, Problems in Aging. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All Specialties. **Cost:** $50. **Contact:** Henry

Ford Office of Medical Education (313) 876-1464. **Approved for:** 7 hours of Category I Credit.

Date: May 21, Hypertension Seminar. Location: Pontiac General Hospital. **Sponsor:** Department of Family Practice, Pontiac General Hospital. **Co-Sponsor:** Michigan Academy of Family Practice, Oakland Health Education Programs. **For:** Family Physicians. **Cost:** No charge. **Contact:** Esly S. Caldwell, II, MD, Director of Education, Family Practice Department, Pontiac General Hospital, Pontiac, MI 48053. **Approved for:** 3 hours of Category I Credit.

Date: May 23-25, Postgraduate Course on Medical Genetics. Location: Towsley Center, U of M Medical Center, Ann Arbor. **Sponsor:** American College of Physicians. **Co-Sponsor:** University of Michigan Medical School. **For:** Primary physicians, internists, pediatricians, obstetricians. **Cost:** $175 for non-members, $120 for members. **Contact:** ACP Registrar of Postgraduate Courses, 4200 Pine St., Philadelphia, 19104. **Approved For:** 21¼ hours of Category I Credit.

Date: May 24, Chronic Obstructive Pulmonary Disease. Location: Park Place Motor Inn, Traverse City. **Sponsor:** Michigan Lung Association and U-M School of Public Health CME Advisory Committee. **For:** All specialties. **Cost:** $10. **Contact:** Tom Sovine, Michigan Lung Association, 403 Seymour Ave., Lansing, 48914. **Approved for:** 4 hours of Category I credit.

Date: May 25, Multiple Myeloma. Location: Grace Central Hospital. **Sponsor:** WSU School of Medicine. **For:** All interested physicians. **Cost:** $20. **Contact:** Dorothy Bewley, Department of Oncology, Wayne State University, 4160 John R., Detroit 48201. **Approved for:** 2½ hours of Category I Credit.

Date: May 26, Pathology Conference. Location: Towsley Center, U of M Medical Center. **Sponsor:** U of M Office of Intramural Education. **For:** Pathologists. **Cost:** To be determined. **Contact:** U of M Office of Intramural Education*. **Approved for:** 6 hours of Category I Credit.

Date: May 26, Michigan Primary Care Preceptorship Program. Workshop. Location: Holiday Inn, Marquette, MI. **Sponsor:** Michigan State University College of Human Medicine. **For:** Primary Care Physicians. **Cost:** None. **Contact:** Lynda Farquahar, (517)353-5440. **Approved for:** 4 hours of Category I Credit.

Date: June 2-3, Blood Banking. Location: Towsley Center, U-M Medical Center. **Sponsor:** Office of Continuing Education, Dept. of PGM/HPE. **Co-sponsor:** American Society for Medical Technology. **Cost:** $75. **Contact:** Office of Continuing Education, Dept. of PGM/HPE, U. of M.*. **Approved for:** 13 hours of Category I credit.

Date: June 3-4, Arthritis Symposium. Location: Hyatt Regency Dearborn. **Sponsor:** Michigan Chapter, Arthritis Foundation. **For:** All specialties. **Cost:** $25. **Contact:** James J. Lightbody, MD, Michigan Chapter, Arthritis Foundation, Village Plaza, Suite 605, 23400 Michigan Ave., Dearborn, 48124.

Date: June 7, Continuing Pathology Conference. Location: Towsley Center, U-M Medical Center. **Sponsor:** Office of Continuing Education, Dept. of PGM/HPE. **Cost:** $20. **Contact:** Office of Continuing Education, Dept. of PGM/HPE, U. of Michigan*. **Approved for:** 6 hours of Category I credit.

Date: June 8-10, Pulmonary Disease Workshop. Location: Towsley Center, U-M Medical Center. **Sponsor:** Office of Continuing Education, Dept. of PGM/HPE. **Co-sponsor:** M.A.F.P. **Cost:** $180. **Contact:** Office of Continuing Education, Dept. of PGM/HPE, U. of M.*. **Approved for:** 22 hours of Category I credit.

Date: June 9-11 — Annual Keyport Trauma Symposium. Location: Otsego Ski Club, Grayling. **Sponsor:** Michigan Committee on Trauma, American College of Surgeons. **For:** All specialties. **Cost:** $25. **Contact:** B. E. Henig, MD, 308 Michigan Ave., Grayling. **Approved for:** 12 hours of Category I credit.

Date: June 10-11, 16th Annual Kidney Symposium. Location: Hilton Inn, Lansing. **Sponsor:** Michigan Kidney Foundation, MSU College of Human Medicine. **For:** Physicians, nephrologists, social workers, nurses. **Cost:** $40. **Contact:** Michigan Kidney Foundation, 3378 Washtenaw, Ann Arbor, 48104. **Approved For:** 9 hours of Category I credit.

Date: June 10 - 12, Workshop on Human Sexuality for Physicians and Health Care Professionals. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital Department of Psychiatry. **For:** Physicians, Psychologists, Social Workers and other Health Care Professionals. **COST:** $125. **Contact:** Norman Rosenzweig, MD, (313) 272-6000, Ext. 8516. **Approved for:** 22 Hours of Category I Credit.

Date: June 15-24, Advanced Institute in Methods of Immunological Diagnosis. Location: Cranbrook Educational Community, Bloomfield Hills. **Sponsor:** Wayne State University School of Medicine. **For:** All interested physicians. **Cost:** $600. **Contact:** Noel R. Rose, MD, PhD, Department of Immunology and Microbiology, WSU, 540 East Canfield, Detroit 48201. **Approved for:** 60 hours of Category I credit.

Date: June 17-18, Michigan Thoracic Society Annual Meeting, with American College of Chest Physicians, Michigan Chapter. Location: Kalamazoo Hilton Inn. **Sponsor:** Michigan Thoracic Society and Michigan Lung Association. **For:** All specialties. **Cost:** None. **Contact:** Tom Sovine, Michigan Lung Association, 403 Seymour Ave., Lansing, 48914. **Approved for:** 9 hours of Category I credit.

Date: June 20-24, Northern Michigan Summer Conference. Location: Shanty Creek Lodge, Bellaire. **Sponsor:** Office of Continuing Education, Dept. of PGM/HPE. **Cost:** $200. **Contact:** Office of Continuing Education, Dept. of PGM/HPE, U. of M.*. **Approved for:** 22 hours of Category I credit.

Date: June 22, Carcinoma of the Thyroid. Location: Grace Central Hospital, Detroit. **Sponsor:** WSU School of Medicine, Dept. of Oncology. **For:** All interested physicians. **Cost:** $20. **Contact:** Dorothy Bewley, (313-494-6025), 4160 John R, Detroit, Mi 48201. **Approved for:** 2½ hours of Category I Credit.

Date: June 23-25, Macular and Retinal Vascular Disease Conference. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital, Detroit Institute of Ophthalmology, Bon Secours Hospital. **For:** Ophthalmologists. **Cost:** $200 for practicing physicians, $100 for residents and fellows. **Contact:** Judy Dara, Detroit Institute of Ophthalmology, 15401 E. Jefferson, Grosse Pointe Park, 48230 (313)824-4800. **Approved for:** 16 hours of Category I credit.

Date: July 28-29, Annual Coller-Penberthy-Thirlby Medical Conference. Location: Park Place Motor Inn, Traverse City. **Sponsor:** Munson Medical Center, Traverse City. **For:** All specialties. **Cost:** None. **Contact:** Kenneth H. Musson, MD, Grand Traverse Ophthalmology Clinic, PC, 1105 E. Front St., Traverse City, 49684. **Approved for:** 9 hours of Category I credit.

Date: Aug. 6-10 — Annual Meeting and Scientific Program. Location: Sugar Loaf Resort, Cedar. **Sponsor:** Michigan Academy of Family Physicians. **For:** Family Physicians. **Contact:** Rita Feldkamp, MAFP executive secretary, 933 Wing St., Plymouth, 48170. **Approved For:** 28½ hours of Category I credit.

Date: Aug. 13-14, AMA Regional CME Program. Location: Northern Michigan University, Don Bottom Conference Center, Marquette. **Sponsor:** American

(Continued on page 280)

Where do you stand on these issues?

Pro Con
☐ ☐ Maternal and child care programs
☐ ☐ Federal aid to medical students
☐ ☐ Extending private health insurance to everyone
☐ ☐ Nationwide program of community emergency medical services
☐ ☐ Reform of the tort system of malpractice adjudication
☐ ☐ Maximum Allowable Cost (Drug) Regulations
☐ ☐ Health Planning Act of 1974
☐ ☐ Federal control of the number and location of residences
☐ ☐ Federal standards for licensure and relicensure
☐ ☐ Federal national health service

If you're for the first five but against the second five, you stand where the AMA stands.

The AMA has vigorously supported virtually all recent legislation to provide more and better health care for the public. The AMA has just as staunchly opposed any plan that would infringe on your right to practice the way you choose.

On such vital issues, the AMA is the most effective and influential spokesman the profession has. With your support, it can be even more effective.

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Medical Association. **For:** All specialties. **Cost:** Prices for five courses, $70; Advanced CPR, $160. **Contact:** Gale Jewitt, AMA, (312) 751-6570. **Approved for:** 6 hours of Category 1 credit, 14 for advanced CPR.

Continuing Courses

Date: Monthly, Ob/Gyn Journal Club. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** All interested physicians. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Monthly Urology Journal Club; Location: Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Urologists; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital****; **Approved for:** 2 hours of Category I Credit.

Date: Continuing Quarterly Journal Club — Surgery; Location: Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Surgeons; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Monthly, Cleft Palate Clinic. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital****. **For:** Oral Surgeons, plastic surgeons, pediatricians. **Cost:** None. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 3 hours of Category I Credit.

Date: Monthly, Tissue Audit (Cancer). Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Surgeons, ob-gyns, pathology, radiology. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 2 hours per session Category I Credit.

Date: Monthly Lecture Series in Ophthalmology; Location: Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Ophthalmogists; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Every Tuesday — Psychiatry — Special Problems Seminar; Location: Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Psychiatrists; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital****; **Approved for:** 2 hours of Category I Credit.

Date: Every Tuesday morning, Gynecology/Obstetrics Combined Grand Rounds. Location: Jackson Auditorium, Hutzel Hospital. **Sponsor:** Wayne State University Department of Gynecology-Obstetrics. **For:** All interested physicians. **Cost:** No charge. **Contact:** Wayne State University, Division of CME**. **Approved for:** 4 hours each of Category I Credit.

Date: Wednesdays, Sept. 14 - Nov. 16, Cardiology Seminars. Location: St. John Hospital, Detroit. **Sponsor:** St.

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John Hospital. **For:** All specialties. **Cost:** $200. **Contact:** Department of CME, St. John Hospital, (313)881-8200, ext. 321. **Approved For:** 2 hrs per session hours of Category I Credit.

Date: Thursdays, Sept. 15 - Nov.17, Nuclear Medicine in Clinical Practice. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** All Specialties. **Cost:** $200. **Contact:** Department of CME, St. John Hospital, (313)881-8200, ext. 321. **Approved for:** 2 hrs per session hours of Category I Credit.

Date: Each Wednesday, Detroit Medical Center Hand Conference. Location: Classroom 3, Second Floor, Webber Wing, Harper Hospital, Detroit. **Sponsor:** Wayne State University. **For:** Surgeons. **Cost:** No charge. **Contact:** Joseph L. Posch, MD, Fourteenth Floor, Kales Building, 76 W. Adams, Detroit 48226. **Approved for:** Hour-for-hour Category I credit.

Date: Second Thursday of each month, Inter-Hospital Pathology Slide Conference. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** Pathologists. **Cost:** No charge. **Contact:** Department of CME, St. John Hospital, 22101 Moross Road, Detroit, 48236, (313) 881-8200. **Approved for:** 3 hrs. each date Category I Credit.

Date: Saturdays, Morbidity and Mortality Conference. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital Department of Surgery. **For:** Surgeons. **Cost:** None. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 2 hours of Category I Credit per session.

Date: Every Saturday, Weekly Conference. Location: Gamble Building, Burns Clinic/Little Traverse Hospital, Petoskey. **Sponsor:** Burns Clinic/Little Traverse Hospital. **For:** All interested physicians. **Cost:** None. **Contact:** Ernest W. Carpenter, MD, 560 West Mitchell, Petoskey, 49770.

Date: Begins September, 1976, Continuing Training in Family Therapy. Location: Suite 1212, North Park Plaza, 17117 W. Nine Mile Road, Southfield. **Sponsor:** Family Institute of Southeastern Michigan. **Co-sponsor:** Ackerman Institute. **For:** Psychotherapists. **Cost:** Varies according to time put in. **Contact:** Carolyn R. Tourkow, MSW, director, Family Institute of Southeastern Michigan. **Approved for:** Hours vary with time spent.

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*Office of Intramural Education, University of Michigan Medical Center, Dep't. of PGM/HPE, Ann Arbor, 48109

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***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902

****Department of CME, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 272-6000

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Heartbeat

By Mert Scholten
MSMS Communications Department

Robert W. Black, MD, Detroit, former chief of staff at Harper Hospital, is first chief of staff of the newly-combined Harper-Grace Hospitals.

Maynard M. Farhat, MD, James W. Ferris, MD, Julius J. Gutow, MD and Lewis D. Kaufman, MD, Flint, were honored recently for their combined 160 years of public service. The Genesee County Medical Society Auxiliary cited each on MD Appreciation Day. The event singles out those with 40 years of service to the profession.

Lee E. Feldkamp, MD, Plymouth, member, Board of Directors of the American Academy of Family Physicians, is new chairman of the Academy's Commission on Membership and Member Services.

Richard Kraft, MD, Ann Arbor, head, Department of Surgery, St. Joseph Mercy Hospital, is the L. Kraeer Ferguson, MD, Visiting Professor of 1977 at the Medical College of Pennsylvania.

Larry S. Matthews, MD, Ann Arbor, U of M orthopedic surgeon, is a recipient of the American Orthopedic Association Traveling Exchange Fellowship which is supporting his visits April 12 - May 24 to 15 orthopedic centers in England. He is one of four young U.S. surgeons so honored this year.

George Morley, MD, Ann Arbor, is one of 15 Fellows of The American College of Obstetrics and Gynecology selected to participate in the "Parade of Professors" program this month at the Annual Clinical Meeting of the specialty group.

Kenneth E. Rowe, MD, Calumet, is new acting health officer-medical director of the Dickinson-Iron District Health Department. He replaces Joyce Gendzwill, MD, who resigned.

Donald N. Sweeny, Jr., MD, Grosse Pointe Farms general surgeon and member of the Michigan Medical Practice Board, is an appointee to the new Physicians' Assistants Advisory Committee. The Committee is to develop and implement rules and regulations governing physicians' assistants under the auspices of the Michigan Medical Practice Board.

Morris Weiss, MD, Southfield child psychiatrist, is the new president of the Michigan Council of Child Psychiatry. He succeeds Saul I. Harrison, MD, of Ann Arbor.

Michigan Authors . . . Otto Gago, MD, Ann Arbor, "A Different Approach for the Total Correction of Tricuspid Atresia," the *Journal of Thoracic and Cardiovascular Surgery* . . . **Harry Richter, MD, Ann Arbor,** "Acoustic Trauma," *Laryngoscope* . . . **Thomas C. Shope, MD,** et. al., Detroit, "Epidemic Measles in a Highly Vaccinated Population," March 17, 1977, *The New England Journal of Medicine.*

MSMS leaders recently held their annual meeting with the governor to discuss current issues of importance to the medical profession. From left, they are James D. Fryfogle, MD, Detroit, speaker of the MSMS House; Ernest P. Griffin, Jr., MD, Flint, MSMS Council chairman; Gov. Milliken; Robert M. Leitch, MD, Battle Creek, then MSMS president, and Marion G. McCall, MD, Detroit, MSMS councilor.

Judicial Commission rules on telephone listings

By John M. Malone, MD
Chairman, MSMS Judicial Commission

Recently General Telephone Company of Michigan began listing physicians by their specialties in the Yellow Pages. You will recall that Michigan Bell Telephone Company instituted this practice some time ago.

At its January meeting, the Judicial Commission authorized the same procedure for screening such listings as had been previously authorized for Michigan Bell, as follows:

The Judicial Commission has supplied to General Telephone a listing of specialties which has been adapted from the AMA specialty listings and which the Commission feels is appropriate for Michigan. A copy of this listing is enclosed for your information.

While General Telephone has its own safeguards to make sure that only licensed physicians are listed, the Commission feels that it is the responsibility of the component medical society to check the appropriateness of the listings, i.e., to be sure that those listed as specialists are in fact qualified to practice in those specialties.

Because of GTE timetables for publication of directories, which of necessity are somewhat rigid, the best time to check these listings and inform General Telephone of any problems is immediately after the directory for your area is published. If there are any problems, please contact your local Yellow Pages representative or E. J. Fillipow, Division Manager, General Telephone Directory Company, 1825 Ruddiman Drive, North Muskegon, Michigan 49445, to advise the telephone company of the problem.

We would appreciate your efforts to be sure that accurate information appears in the Yellow Pages regarding medical specialists. Please contact the Judicial Commission at MSMS headquarters regarding any questions you might have.

Specialty Listings For Michigan Bell and General Telephone Companies

(As approved by the Judicial Commission
Michigan State Medical Society,
December 10, 1975)

Aerospace medicine
Allergy
Anesthesiology
Cardiovascular diseases
Dermatology
Endocrinology
Family practice
Gastroenterology
General practice
Geriatrics
Gynecology
Hematology
Infectious diseases
Internal medicine
Legal medicine
Nephrology
Neurology
Neurology, child
Neuropathology
Nuclear medicine
Obstetrics and gynecology
Occupational medicine
Oncology and neoplastic diseases
Ophthalmology
Otology
Otorhinolaryngology
Pathology
Pediatrics
Pediatrics, allergy
Pediatrics, cardiology
Physical medicine and rehabilitation
Psychiatry
Psychiatry, child
Public health
Pulmonary diseases
Radiology
Radiology, diagnostic
Radiology, therapeutic
Rheumatology
Surgery, abdominal
Surgery, cardiovascular
Surgery, colon and rectal
Surgery, general
Surgery, hand
Surgery, head and neck
Surgery, neurological
Surgery, orthopedic
Surgery, pediatric
Surgery, plastic
Surgery, thoracic
Surgery, vascular
Urology

Your tax calendar — 2nd and 3rd quarters

April 25

EMPLOYERS must file Michigan unemployment taxes contribution report (MESC 1020).

April 30

EMPLOYERS must file Form 941 for income tax withheld and social security taxes for the first quarter of 1977 and pay taxes due. If timely deposits were made, see May 10.

EMPLOYERS must file Form 508 and must deposit Federal unemployment tax liability with a depositary. No deposit is necessary if liability for the quarter is not more than $100.

ALL PRACTICES must file the Michigan Single Business Tax Form, along with the quarterly estimated payment.

INDIVIDUALS must file 1976 City Income Tax Forms where applicable, along with the quarterly payment.

May 10

EMPLOYERS who have made timely deposits in full payment of all income taxes withheld and social security taxes due for the first quarter of 1977, file first quarter return (Form 941).

May 16

EMPLOYERS who have pension, annuity, stock bonus, profit-sharing, or other funded plans of deferred compensation must file Forms 5500, 5500-K, and 5501 (whichever applies).

May 31

CORPORATIONS must file the Michigan Annual Report Form.

June 15

INDIVIDUALS must pay the second installment of their 1977 estimated income tax. Use Form 1040-ES.

CORPORATIONS must pay the balance of their 1976 income tax liability. The second installment of 25% of their 1977 estimated income tax liability is due and should be made to a depositary. Use Form 503.

June 30

ALL PHYSICIANS must pay the quarterly estimated payment of the Michigan Single Business Tax.

INDIVIDUALS must pay the quarterly installment on City Income Taxes (where applicable).

July 25

EMPLOYERS must file Michigan unemployment taxes contribution report (MESC 1020).

August 1

EMPLOYERS must file Form 941 for income tax withheld and social security taxes for the second quarter of 1977 and pay taxes due. If timely deposits were made, see August 10.

EMPLOYERS must file Form 508 and must deposit Federal employment taxibility with a depositary. No deposit is necessary if liabilty for the quarter is not more than $100.

August 10

EMPLOYERS who have made timely deposits in full payment of all income taxes withheld and social security taxes due for the second quarter of 1977, file second quarter return (Form 941).

September 15

INDIVIDUALS must make the third installment on their 1977 estimated income tax (Form 1040-ES).

CORPORATIONS must pay to a depositary their third installment of 25% of their 1977 estimated income tax (Form 503).

September 30

INDIVIDUALS must pay the third installment on their estimated City Income Taxes (where applicable).

In Memoriam

Max E. Auble, MD
Detroit

Max E. Auble, MD, on the staff of Providence Hospital, Detroit, for 41 years, died March 16 at the age of 65. Doctor Auble, former chief of staff and chief of surgery at Providence, was a graduate of the University of Michigan Medical School. He served as an instructor for the School of Nursing there and was chairman of the Qualifications Committee and the Medical Nursing Committee. He was also a fellow of the American College of Surgeons and the Detroit Academy of Surgeons.

Ralph R. Piper, MD
Detroit

Medical superintendent of the former Detroit Receiving Hospital for 23 years, Ralph R. Piper, MD, 78, died Feb. 28. Doctor Piper had served as city physician during the 1940's and as director of the Wayne County Medical-Dental Bureau, a clearing house for public relief during the Depression years. He was a graduate of the Wayne State University School of Medicine.

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Every physician should have AAMA member in the office

By Martha Climo
Special to **Michigan Medicine**

The State of Michigan Branch, American Association of Medical Assistants (AAMA), grows increasingly important as medical assistants take on greater responsibility in doctors' offices.

(A medical assistant is any person who is actively employed or supervised in an administrative or technical capacity by a physician.)

The purpose of the 20-year-old AAMA is to bring assistants into closer relationship with their doctors, to exchange ideas, to strive to improve public relations in the medical profession, to inspire assistants to give honest, loyal and more efficient service to the profession and public, and to provide educational and informative service to the AAMA membership. In Michigan, the organization holds regular meetings, educational seminars, an annual convention and works on projects to raise money for the poor and the handicapped.

Mrs. Peterman

Doctor Hills advises

David Hills, MD, chief of staff, Memorial Hospital, St. Joseph, has been an advisor to the state AAMA board for five years.

As this years' board chairman, Doctor Hills encourages medical assistants to be involved in their professional activities. He tries to attend all the AAMA state branch meetings and to make useful suggestions on educational matters.

In the past 17 years as Doctor Hills has practiced family medicine, he says he has noticed medical assistants have grown more sophisticated.

"They have been given more responsibilities, particularly in terms of passing on correct information to patients," he says.

Doctor Hills believes doctors can help their medical assistants by being more understanding of assistants' roles.

"Sometimes doctors become impatient with medical assistants without realizing some of the problems their assistants are up against," he says.

Mrs. Peterman stresses manner

Mrs. Pauline Peterman, a registered nurse from Kalamazoo, is a medical assistant and is this year's state branch AAMA president. She sees her responsibility as keeping the county organizations informed of what is going on at the state level and encouraging better medical assistants through the organization's educational seminars.

Mrs. Peterman praises the doctors she works for who encourage her and allow her time off from her regular work to run the state organization. She works at several Kalamazoo clinics and assists doctors who care for amputees and patients afflicted with scoliosis, myelomeningocele and orthopedic problems. She records necessary information from the patients for the doctors, handles referrals, helps with X-rays, screens children for scoliosis, and schedules patients for surgery.

Mrs. Peterman sees her job as paving the way for the doctors, and stresses the significance of a medical assistant's manner toward people and their problems.

"The patient can tell by your voice what your attitude is and whether or not you care," she says. "Your voice means so much to the patient on the telephone.

"As for problems," she continues, "We have a lot of MDs who don't care about the AAMA. We have many MDs who are interested, but whose assistants don't want to get involved.

"If we could interest both assistants and the MDs, the MDs would pay the AAMA dues," she said.

Mrs. Peterman's dream is to see that every MD's office has a representative to the AAMA.

Mrs. Boers supports education

Another long-time, active member of the AAMA is speaker-of-the-

Mrs. Boers

house, Mrs. Betty Boers, medical assistant to ophthamologist Ray Pinkham, MD.

Mrs. Boers says her office is low-key, unlike some of the larger offices where several medical assistants work. She answers the telephone, makes appointments, assists in surgery, writes checks and does ordinary transcriptions.

She praises the two year medical assistants' course which enables people to become certified medical assistants.

"Now, it's a self-gratification course, but in years to come, I think people who work in doctor's offices will have to be certified as medical assistants. At first, most people weren't interested in the CMA program. Now it's the thing."

Mrs. Boers beleives strongly in the educational and informational value of the organization. The AAMA invites doctors to speak at their seminars and at the state convention.

"The seminars are helpful," she says, "because people get together and talk about similar problems."

Doctor Anita Herald seeks state nutrition goals

Governor William G. Milliken established the Michigan Advisory Commission on Nutrition and an Office of Nutrition in January, 1975. He charged the Commission to develop a comprehensive state plan for nutrition that would translate into action the commitment that Michigan has made to upgrade the nutritional status of its citizens.

According to the Plan, it was the lack of priority and coordination plus rising unemployment, higher costs for food and changes in the food industry which have led to fragmented consumer education, inadequate provision of services, limited implementation of food programs and the lack of a mechanism that could hold those responsible for the services accountable for the status of their program. And it was these ideas that originally caused Governor Milliken to issue an executive order to establish the Office of Nutrition and the Advisory Commission on Nutrition.

The Office of Nutrition submitted the state plan for nutrition in late January, 1977. The Governor is now deciding whether or not to continue an administrative mechanism such as an Office of Nutrition, and if so, what form it should take and where it should be placed within the structure of the state government.

During the past two years, Chairwoman Laura Hess and her staff have familiarized themselves with nutrition programs and issues in the state of Michigan. Anita Marie Herald, MD, Muskegon, Officer of the Muskegon County Health Department, was one of 15 members who served on the Advisory Commission. According to Doctor Herald, the only MD on the board, the purpose of the Commission on Nutrition was to examine the nutritional status of the people in the state of Michigan.

"For the first year I was on the Commission," Doctor Herald said, "Chairwoman Laura Hess and I examined nutrition programs in the state to see what kinds of objectives and goals we could set up for the Commission."

The Commission identified 12 major areas of importance. They included: (1) nutrition education in schools; (2) infant/child nutrition programs; (3) nutrition counseling; (4) local responses to nutritional needs; (5) alternate care facilities other than home, hospitals or schools; (6) current factors in food delivery; (7) consumer nutrition education; (8) adult nutrition programs; (9) nutrition manpower traineeships; (10) state responses; (11) ethnic lifestyles and (12) alternate food delivery systems.

"In order to move ahead in the area of nutrition," Doctor Herald said, "studies will have to be made. We already have good data from the Medicaid program, but other groups such as the elderly should be screened.

"Some of the top priorities for the Office of Nutrition should also include working with the Department of Education to find a way to incorporate nutrition courses in the elementary school curriculum.

"We also found out that state medical school programs do not offer courses on nutrition which should be

NUTRITION/*Continued*

essential and we learned that prisons only have a half-time dietician coordinating menus. However, the Commission has neither the money nor the resources to do any studies. If the office is funded, many studies should be done."

Doctor Herald also said that another area which needs attention is family health planning. She said that ADC mothers want about the same number of children that middle class women want. "If the state pays for birth control for one woman per year, it costs the state $169 whereas if the state pays for the woman's pregnancy, delivery and child care, it costs the state $2,000.

"We run a supplemental feeding program at the county level for low income mothers-to-be. Nutrition is key here in making sure that the mother has the proper nutrition particularly in the last three months of pregnancy and that the baby has the proper nutrition particularly in the first six months of its life."

"Nutrition for us in Michigan has tremendous importance on two fronts," Gov. William Milliken has said. "The issue of hunger, sadly a stark reality for far too many, and secondly, the matter of poor nutritional habits that allow many people to suffer from chronic diseases and other nutritional-related ailments.

"We can no longer rely on emergency first aid for treatment of deep-seated nutritional problems in Michigan. We want a program of positive and continuing action. Nutrition and nutrition-related programs must be given priority attention."

He said he intends to do all he can to see that this priority is recognized throughout the state government.

According to Ms. Hess, the new state plan includes 10 major goals:

1) To maximize the ability within the state to positively address nutritional problems.
2) To ensure optimal nutritional support for infants/preschool children.
3) To ensure optimal nutritional support for school age children.
4) To develop an awareness of principles of normal nutrition among school age children.
5) To ensure accessibility to means of optimal nutritional support for adults.
6) To increase consumer understanding of and adherence to nutrition principles.
7) To maximize the consumer's ability to restore and maintain nutritional health by practicing sound nutrition principles.
8) To provide optimal nutrition support for residents of alternate care facilities.
9) To provide optimal nutritional support for residents of state institutions.
10) To maximize accessibility to quality food at reasonable costs.

(Climo)

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Americans healthier each year

By Richard E. Palmer, MD
AMA President

Americans are, overall, a healthy nation. And we're getting steadily healthier.

On the adverse side, the cancer death rate is rising. The number of "slow down" days and days of bed illness per person per year have risen slightly.

But there most definitely is a bright side to the nation's health picture. Some of the pluses achieved in recent years have been little short of spectacular.

Maternal deaths were reduced by 26 per cent in 1975. Infant deaths have declined by 20 per cent in five years. Of the leading causes of death in 1970, rates for all but one — cancer — have been substantially reduced. Life expectancy has been increased by a year and a half since 1970.

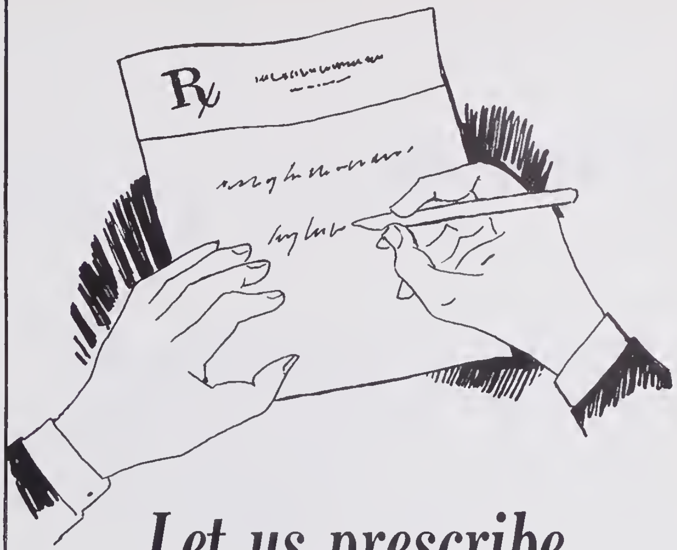
From 1970 to 1975 deaths from heart disease dropped 6.4 per cent. Deaths from stroke in the same years declined by 9.9 per cent. Accidents as cause of death dropped by 15.6 per cent. Deaths from influenza and pneumonia declined by 12.6 per cent. And so on for the other leading causes of death.

In fact, fewer Americans are dying each year per 100,000 population. This ratio dropped by 5.2 per cent from 1970 to 1975. The category of bronchitis, emphysema and asthma is no longer among the top 10 killers. Its place was taken over by suicide.

Life expectancy at birth for all Americans in 1970 was 70.9 years. By 1975 the figure was up to 72.4 years. Since the turn of the century, when average life expectancy was 47.3 years, more than half a lifetime has been added.

Conspicuous gains have been reported in recent years against maternal deaths and deaths of infants. Maternal deaths per 100,000 live births dropped from 83.3 in 1950 to 10.8 in 1975. In the same quarter century, infant deaths (below the age of one year) dropped from 29.2 to 16.1 per 1,000 live births. Preliminary figures for 1976 indicate that the infant death rate has declined even more, to 15.2.

Americans are a healthy race, and they're getting healthier year by year.



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MEDICAL OFFICE SPACE available in near future in Livonia near Plymouth and Farmington Roads. Medical Village type complex with portion occupied by busy OB-GYN practice. Suitable for Internist, Family Practice, or Surgical Specialties. Call (313) 477-8333 Mr. Robert Thompson.

METAL PLAQUE — Honorary certificates, diplomas, photos, etc. perfectly reproduced in bright silver-toned metal with black lettering, all the clarity of the original yet immune to deterioration. Mounted on richly finished walnut base 10 × 12 for only $34.95. Allow three weeks. Perma-Plaque, 778 Rivard, Grosse Pointe, 48230 (313) 884-9399.

VERY GOOD OPPORTUNITY for a GP. I retired the first of the year. Beautiful stone building, tiled roof, for sale. Across from courthouse. Includes furnishings, equipment, instruments, and drugs. Very reasonable. Phone (517) 875-3960, A. L. Aldrich, MD, Ithaca, MI 48847.

WANTED: Opthalmologist: Get out of the city rat race. I need help. Should gross 6 figures first year. Would like to slow down on surgery. New office adjoining mine. Write, call or visit. M. D. Bentley, M.D., 502 Cobb Street, Cadillac, Mi. 49601 (616) 775-9353.

NORTHERN MICHIGAN COMMUNITY needs additional doctors. Doctors office building available, built as a doctor's office. $300 per month rent. Contact Robert C. Redman, (616) 839-7272.

PAW PAW AREA — Need for anesthesiologist, orthopedic surgeon and general practitioner. Modern well-equipped, fully accredited general hospital located in Paw Paw serves growing area in SW Michigan close to Kalamazoo. Office space and equipment available. Excellent recreational and cultural area in the heart of Michigan's Grape & Wine Country. Good schools, all denominations of churches. A fine place to live. Contact: Michael H. Payne, Administrator, Lake View Community Hospital, P. O. Box 209, Paw Paw, MI 49079. Phone: (616) 657-3141.

WANTED: Staff physician, Michigan license required, for 350-bed fully accredited hospital for the care of rehabilitation, tuberculosis, psychiatric and chronic disease patients. 40 hours week. Excellent salary and fringe benefits. Contact: Personnel Director, Saginaw Community Hospital, 3340 Hospital Road, Saginaw, Michigan 48605.

FACULTY/STAFF PHYSICIAN. A board certified Family Practitioner or a Physician finishing a Family Practice Residency is needed for a growing Family Health Center. The center serves as the health care focus for a large segment of the community as well as the ambulatory experience for 18 Family Practice Residents. Responsibilities include teaching in the inpatient and ambulatory setting, some direct patient care activities, and the responsibility for the delivery of care in both the inpatient and outpatient settings. Salary and fringes negotiable. Contact Theodore Aldhizer, M.D., Medical Director, Family Health Center, Saint Mary's Hospital, Grand Rapids, Michigan 49503.

BUSY GENERAL PRACTICE available for takeover immediately. Leaving for industrial medicine. Southeastern Michigan location in city of 25,000. Call (313) 941-2120 or evening (313) 761-3465.

PEDIATRICS, Educational Program Coordinator. Applications are being accepted for this full time staff position with the Southwestern Michigan Area Health Education Center. To be considered, an individual must be a fully trained pediatrician and certified (or imminently so) by the American Board of Pediatrics. Duties and responsibilities will encompass many areas of activity including undergraduate, graduate and continuing medical education. A complete job description is available upon request. Compensation will include a generous stipend and fringe benefits package as well as a regular appointment to the faculty of the College of Human Medicine of Michigan State University. For details contact: Robert M. Nicholson, MD, Executive Director, Southwestern Michigan Area, Health Education Center, Suite #364, 252 East Lovell, Kalamazoo, MI 49006, (616) 383-7896.

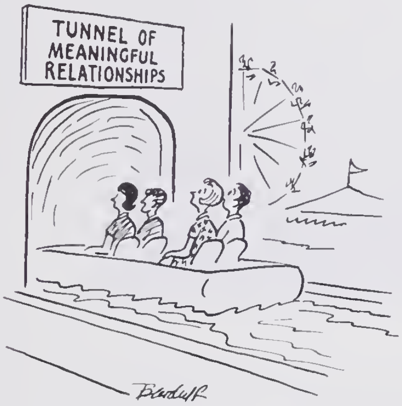
G. P. F. P. needed to associate with three G.P.'s in city with three general hospitals. Excellent fringe benefits, liberal vacations and coverage. Contact A. G. McCuaig, M.D., 719 Capital Avenue, S.W., Battle Creek, MI. Telephone 616/965-2277.

INTERNIST/FAMILY PHYSICIAN. Applicant must be interested in general family medicine for four integrated clinics in city and suburbs. Complete laboratory and nuclear medicine. Foreign graduates must have state license. Liberal salary. Call or write Trail Clinic, PC, Cindy Papuga, Clinic secretary. (313) 861-4400, 18254 Livernois, Detroit 48221.

OB-GYNE — WE ARE SEEKING a board certified or eligible physician to replace an OB partner lost because of health reasons. We are a 20-physician, multi-specialty group located 55 miles northwest of Chicago in the Chain-O-Lakes resort area with easy access to the city. Our candidate will step into an active three-man practice with incentive pay from day one (with a guaranteed minimum draw), malpractice paid, excellent fringe benefits. Our group is physically adjacent to a 144-bed general community hospital and state trauma center. Call or write Jim Dickson, McHenry Medical Group, 1110 North Green Street, McHenry, Ill 60050 — 815/385-1050.

ORTHOPAEDIC SURGEON — WE HAVE an excellent opportunity for a board certified or eligible orthopaedic surgeon to join our multi-specialty medical group as our second orthopod. Expanding practice requires addition to our staff. Guaranteed minimum salary 60K, incentive as full partner from day one, malpractice paid. Located 55 miles northwest of Chicago in Chain-O-Lakes resort region. Our facility is physically adjacent to a 144-bed general community hospital and state trauma center. Excellent support facilities. Call Jim Dickson, Personnel Director, McHenry Medical Group, 1110 North Green Street, McHenry, Ill 60050. 815/385-1050 — ext. 332.

AUTOMATIC REFRACTOR — DIOPTRON, brand new, never used, full 18-month warranty and discount. Must sell due to change in plans. Call (313) 342-6420 after 8:00 P.M. or leave a message with (313) 961-7107 daily.



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Potpourri

By Herbert A. Auer, Executive Editor

"YOU MAY NEVER lose your nervousness when you get up to speak, but I hope you will be able to get all the butterflies to at least fly in formation." That advice was given to Michigan doctors participating in the AMA Regional CME Weekend Course in Public Speaking in Detroit by Nort Enright, instructor from the AMA staff.

* * *

IN HIS EXAUGURAL MESSAGE, Jack G. Lukens, MD, as president of the Kent County Medical Society, offered a set of challenges including one . . . "To convince all KCMS members to join and support the AMA — the only national organization I know representing all practicing physicians and committed to better health legislation and continuing medical education of physicians."

* * *

THE NATION'S DEATH rate in 1975 was the lowest in history — according to 1975 statistics which just became available. It fell to nine deaths for every 1,000 Americans, down from 9.2 in 1974 and 9.5 in 1969.

* * *

TEDDY ROOSEVELT once said, "The first requisite of a good citizen in this republic of ours is that he shall be able and willing to pull his weight."

* * *

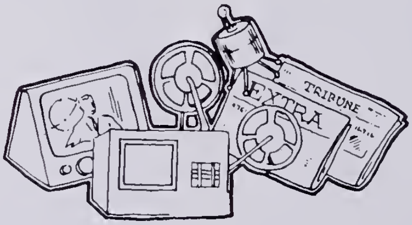
"GOVERNMENT regulations of higher education in some crucial instances have been enacted with little forethought, with trivial purpose and after minimum consultation with the institutions that are affected," declared President W. D. Weatherford of Berea College in his annual report.

* * *

THAT FREE PRESS columnist Jim Fitzgerald, who has been rough several times on Michigan physicians, is taken to task in the MSU Alumni magazine by Editor Ron Karle. "Fitz" has attacked MSU several times too, causing Karle to comment, "Wouldn't it be nice if old Jim came around once in a while to find out — about MSU cancer research, about wastewater research, about the three MSU medical schools, etc?"

* * *

WHAT IS Nelson Rockefeller doing now? Well, he is busy giving speeches, often with rare wit. He usually announces, "My dinner speech tonight is off the record . . . and I authorize you to leak my remarks."



"IT IS HIGH TIME that physicians became realistic about what is happening to themselves and the medical profession. Physicians must get involved in public relations activities to exert their influence in public and medical politics" — so writes Richard J. Ferrara, MD, co-chairman of the Wayne County Medical Society public relations committee in a recent issue of the *Detroit Medical News*.

"THE AMA IS WORKING hard to influence the media to follow a policy of greater fairness and objectivity in its reporting," so declares the AMA in ads that are running in national specialty journals and other publications. John J. Coury, MD, Port Huron, now an AMA Board member, reports that the AMA is "devoting more money and manpower to overcome reporters' basic assumptions," and "that's a long-term educational job."

* * *

THE AUTO INDUSTRY protests because a recent poll revealed that most people think the industry makes 37 cents on the dollar. Instead, the FTC reports profits in 1976 were 5.1 cents on the dollar.

* * *

WHAT'S THE LARGEST item in a family budget? Food? Wrong. The average U.S. household in 1978 will spend $3,354 on food; but will also spend $5,797 to help finance the U.S. government expenditures. And the figure could go higher.

* * *

SOON MANY VISITORS will pour into Michigan for summer fun. Each visitor will spend an average of $24.88 per day and will be responsible for many jobs adding to the income of Michigan residents. Travel and tourism rank as Michigan's second largest industry.

* * *

IN 1980 an estimated 169,000 scholarly scientific articles will be published. That will be quite a jump from 151,000 counted in 1974.

Michigan Medicine Contents

***Michigan Medicine*, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about contemporary issues and actions of the Michigan State Medical Society, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.**

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The Publication Committee of the MSMS Council is the editorial board of *Michigan Medicine* and advises the Council and the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

MICHIGAN MEDICINE is the official journal of the Michigan State Medical Society, published under the direction of the Publications Committee. Published three times a month, 36 issues by the Michigan State Medical Society as its official journal. Second class postage paid at East Lansing, Mich. and at additional mailing offices. Yearly subscription rate, $11.00; single copies, $1.50. Additional postage: Canada, $1 per year; Pan-American Union, $2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to manuscripts, news, exchanges, etc., should be addressed to Judith Marr, Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823. Phone Area Code 517, 337-1351.

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In the next issue . . .

A pull-out reference of Michigan physician demographics.

President's Page

MSMS is in great shape

(The following article is excerpted from the address Doctor Bass delivered as he was installed May 14 as 1977-78 MSMS President.)

Vernon V. Bass, MD
MSMS President

This is a great time to be your president. We, the Michigan State Medical Society, are in great shape.

Never before have we had the security of our self insurance company — Michigan Physicians Mutual Liability Company. Financially secure, the company is comprised of doctors working for doctors for our patients.

Never before has MSMS had so many members. Our membership stands at an all-time high.

Never before have we had such clear-cut directions to our negotiating arm, the Negotiating Committee.

Never before has the Council asked to lead, and taken such innovative steps.

Never before have we been able to print the views and suggestions of so many members in our new *Michigan Medicine.*

Never before has MSMS stood so firm and united as we debate Medicaid and other governmental actions and regulations.

Never before has your AMA delegation been so influential, with Michigan men in so many important positions. There's John J. Coury, Jr., MD, Port Huron, the first-ever AMA trustee from Michigan; Donald Sweeny, Jr., MD, Detroit, chairman, the very prestigious AMA Council on Medical Services. There's John W. Moses, MD, now of Akron, but a Michigan man for many years, on the AMA Council of Medical Education, and George W. Slagle, MD, Battle Creek, immediate past AMA vice president.

Never before has your AMA taken the government to court. Never before has the AMA stirred the alphabet soup and had the chief of HEW apologize.

What I'm saying is that medicine is a favored calling. It has been highly respected since time began. And at least since Hippocrates' time, a moral code was explicit.

Michigan medicine, as far as I can remember, has had crises and problems at different degrees and for different lengths of time. The Michigan State Medical Society always has met the task. So if we stick together, iron out and solidify our wills, there is nothing we can't do. And we can do anything we will to do.

I'm asking you to do your job. Keep yourself informed and become a tightknit group. If Michigan medicine continues to improve it will be because you have done your job.

When **impotence** due to androgenic deficiency is driving them apart

Android®-5 Buccal Tabs
Android®-10 Oral Tabs
Android®-25 Oral Tabs

Methyltestosterone U.S.P. – 5, 10, 25 mg.

New Double-Blind Study ANDROID-25 *vs.* Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

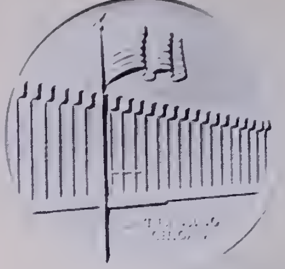
Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males. 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement, +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg., Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg., Postpuberal cryptorchism, 30 mg **REFERENCE: Robert B. Greenblatt, M.D., and D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101 Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg in bottles of 60, 250. Rx only.

BROWN **THE BROWN PHARMACEUTICAL CO., INC.** 2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Write for Reprints and Samples.



MSMS, components begin membership drive

MSMS has begun collecting the names and addresses of newly-licensed Michigan physicians, with the assistance of the Michigan Medical Practice Board. MSMS then writes to each new physician welcoming him or her to Michigan and inviting each to contact the MSMS secretary or local component society for a membership application.

This activity is one of the first steps being taken by MSMS to ensure membership growth, following approval of an extensive membership improvement program by the MSMS Council April 20.

The steps for membership growth were recommended by a special MSMS ad hoc committee formed after the MSMS Council in the fall adopted 11 suggestions for membership recruitment. The original 11 suggestions were made by Councilor Dean Carron, MD, Ann Arbor, and the ad hoc committee was chaired by Councilor Kenneth J. Ray, MD, Detroit.

"I personally feel MSMS and the components should jointly invite every eligible physician to affiliate with the medical organizations," said Doctor Ray in making his committee's report to the MSMS Council. "There are an estimated 1,700 residents in training who are not members and another 800 practicing physicians who are not now members. Our first goals should be to contact the 800 and convince them that they are needed.

"To me, it seems logical to work hardest on the new physicians coming into Michigan and on the young physicians just beginning practice. The longer a physician is not a member the more difficult it may be to convince him to join.

"I can point out to MSMS that if 800 physicians join, MSMS would have an additional income of almost $125,000 — and the components, too, would have considerable new income."

The recommendations are divided into two groups, one for MSMS implementation and the other for county society implementation. They are as follows:

MSMS Activities

1. MSMS should help any component that requests assistance, regardless of the number of physicians in the component area.

2. MSMS should obtain names and addresses of new doctors of medicine licensed by the Michigan Medical Practice Board, to write each welcoming him or her to Michigan and inviting each to contact the secretary for his or her local component society for a membership application.

3. MSMS should conduct some pilot projects to ask physicians why they have joined, or why they have resigned.

4. MSMS should work with any interested component to invite non-member physicians under 40, and non-member, foreign-trained physicians to meetings to discuss membership benefits and medical organizational goals and activities.

(Continued on page 301)

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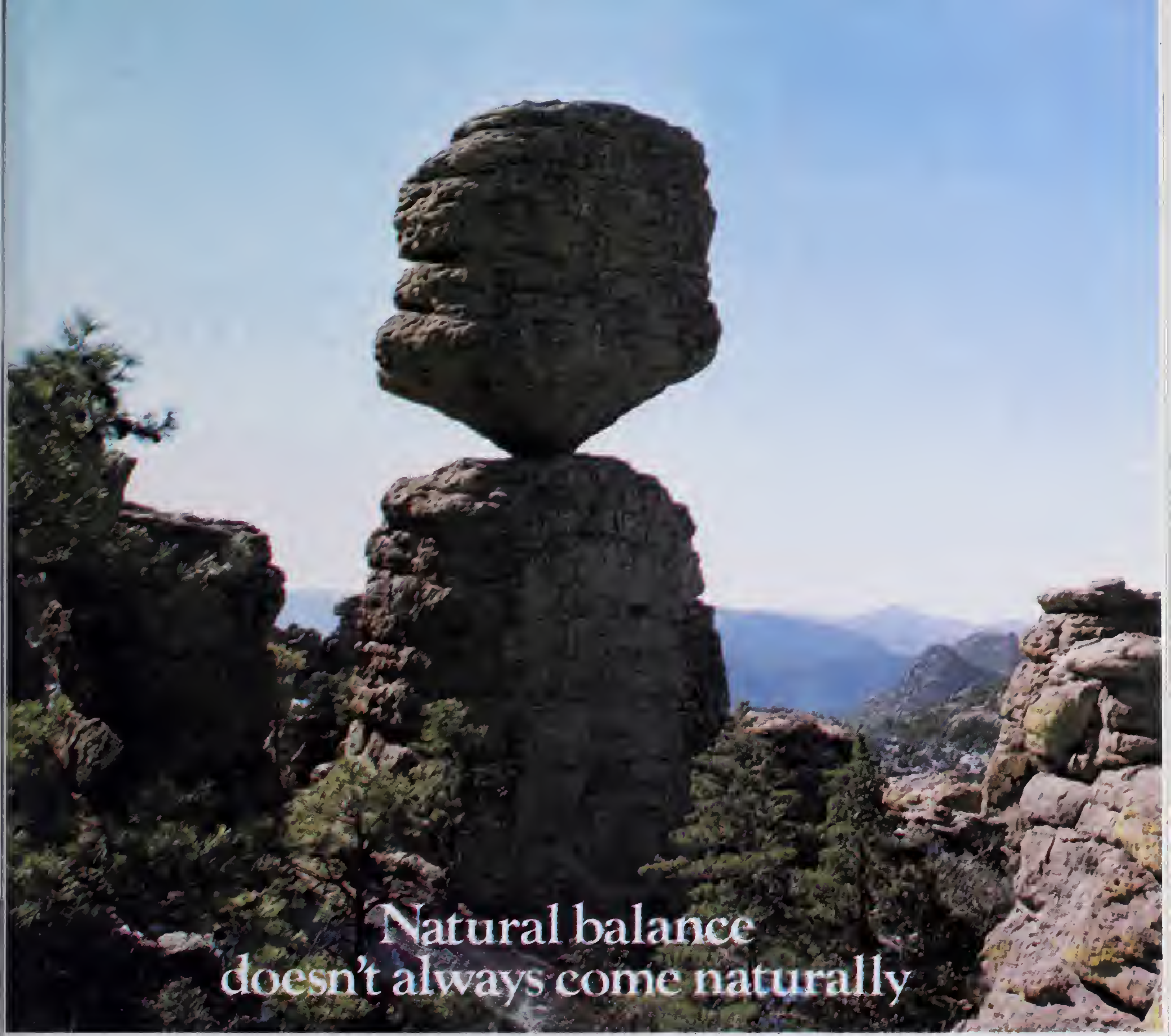

Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

■ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

■ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

■ **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*

DYAZIDE® MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*

Trademark

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

LOWERS BLOOD PRESSURE
CONSERVES POTASSIUM

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* WARNING

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes (see Warnings).

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use **potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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Here are 1976 rulings of MSMS Judicial Commission

By John M. Malone, MD, Chairman MSMS Judicial Commission

Since the MSMS Judicial Commission last reported to the membership in January, 1976, it has discussed many matters of concern to MSMS members in the area of medical ethics and discipline.

Improper conduct with third parties

One of the Commission's major concerns in the past year has been the publicity concerning alleged improper activities by physicians with regard to the Medicaid and Medicare programs and in dealings with other third parties.

The Commission met with the President of the Michigan Medical Practice Board to offer its cooperation in dealing with unethical conduct. The Commission also urged these third party organizations to bring any instances of conduct by physicians which they believed to be unethical to the attention of the appropriate component medical society and the Judicial Committee.

Component medical societies have been asked to be especially alert for possible misconduct on the part of their members and others, to act promptly in disciplining members who engage in unethical conduct, and to promptly report any illegal activities on the part of members *or* non-members to the appropriate authorities.

Physician ownership of clinical labs

Another major area of discussion has been the ethics involved in physician ownership of clinical laboratories. The Commission first considered this question in September 1976 and issued a brief opinion prohibiting such ownership. This ruling was aimed at some specific abuses which had been brought to the Commission's attention. Subsequently, it became apparent that there were many different circumstances under which physicians might "own" a laboratory.

At its April 1977 meeting the Commission considered these varied arrangements and issued the following statement which supersedes the previous opinion:

It is unethical for a physician to accept any inducement for referral by him or her of laboratory services.

It is ethical for a physician to own an interest in a clinical laboratory, provided the patient is not exploited.

It is unethical for a physician to undertake the provision, or supervision, of laboratory services for which he or she is not qualified, or to provide less than quality services.

Other rulings

During the past year the Commission also has:

- Ruled on whether it is appropriate for physicians in a university medical center to treat non-university patients from the community and under what circumstances.
- Outlined criteria for emergency listings in the front of the telephone directory.
- Declined to consider review of "bad testimony" in professional liability cases, but agreed to consider "blatant cases of improper testimony" on an individual basis.
- Declared it unethical for a physician to have a magazine service in his office donated by a pharmacist and with the name of the pharmacist displayed thereon.
- Reiterated the proper conditions of contracts for hospital-employed physicians.
- Considered the authority of consultants in hospital coronary care/intensive care units.
- Declared it unethical for physicians to join with non-physicians in the ownership of psychiatric outpatient clinics.
- Reaffirmed the AMA guidelines for physician listings in telephone directories.
- Called the attention of a hospital to an instance of improper release of medical information.
- Authorized General Telephone Company to use the same specialty listings previously authorized for Michigan Bell Telephone Company.
- Referred several complaints against physicians to the local component society for appropriate action.

During the coming year, the Commission plans to increase its efforts to improve the procedures used by component medical societies in investigating complaints against their members, including promptness of action and proper reporting to complainant. Efforts will be made to further educate and inform component society ethics and mediation committees of their responsibilities in various ethical matters, and the most effective techniques for meeting these responsibilities.

Members of the Commission are:

William C. Baum, MD, Holland
Clarence S. Livingood, MD, Grosse Pointe
Harold A. Machin, MD, Kalamazoo
Joseph L. Ponka, MD, Detroit
Richard L. Rapport, MD, Flint
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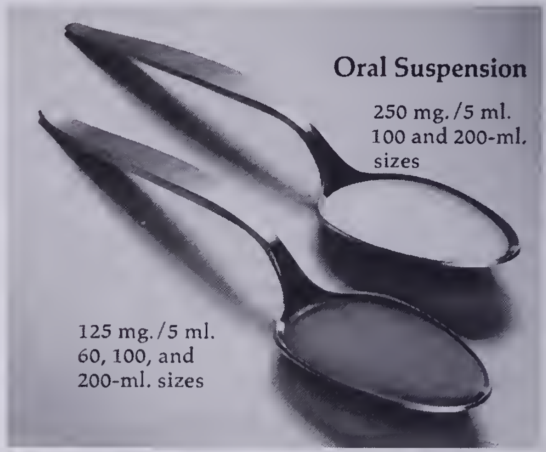

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Meet Doctor Bass: new MSMS president

By Judith Marr, Managing Editor

"Physicians must maintain their own free profession."

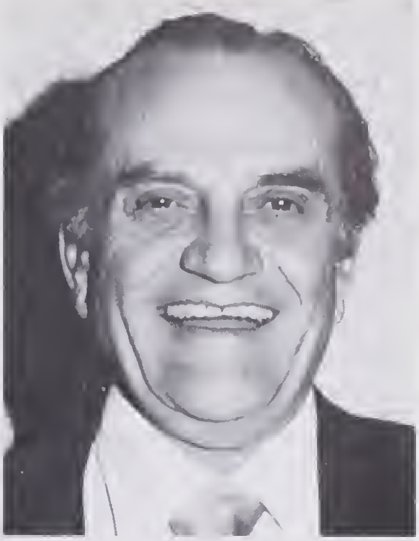
That is a major point of philosophy with new MSMS President Vernon V. Bass, MD. He built his inaugural speech, delivered May 14 in Troy before the 1977 MSMS House of Delegates, around the statement, "I'm proud of my profession."

"Physicians should be looking after physicians, in the old way," he continues. "We tend to criticize before we know what is going on." (See also President's Page article, page 294, this issue.)

Doctor Bass became MSMS president-elect in May, 1976, following eight years as speaker of the MSMS House. He is past president of the Saginaw County Medical Society and former Michigan delegate to the AMA.

Doctor Bass was instrumental in forming the Michigan Physicians Mutual Liability Company. He is currently the MPMLC's first president and chairman of the MPMLC board of directors.

Doctor Bass is a founder and former chairman of the Michigan Doctors Political Action Committee, and formerly chaired the MSMS Legal Affairs Committee. He is a member of the American College of Obstetricians and Gynecologists.



Doctor Bass

"I like to swim, like to play golf, like to putz around with people and travel," says Doctor Bass in further describing his interests. "And I like my cattle."

Doctor Bass' family real estate holdings include the 300-acre Saginaw Valley Charolais Ranch, where he raises purebred cattle.

Doctor Bass, wife Jean and daughter Jill are looking forward to the day when medical society and insurance company activities lessen and they can build their new home on the farm. Doctor Bass is contemplating solar heating and cooling systems and even underground dwellings as energy-saving methods. He has a pond dug near the proposed new homesite and is planning an orchard. Doctor Bass' brother manages the farm.

Doctor Bass enjoys civic and educational projects and has been on the local Chamber of Commerce board. He is current chairman of the audit and budget committee of the Saginaw County Red Feather Agency. He was active in promoting the local college and YMCA.

"If anyone wants to drive (promote) something, I help," he says.

Doctor Bass cautions his fellow physicians, that "if we don't control the medical liability insurance situation, we're dead."

"First I think we need insurance controls, and second a definition of malpractice," he says.

MSMS members may follow Doctor Bass' further views and progress during the year through the pages of *Michigan Medicine* and *Medigram.*

MEMBERSHIP/*Continued*

5. MSMS should mail an occasional issue of *Medigram* (or *Michigan Medicine*) to non-members, complying with the U.S. Post Office limitations for mailing "sample copies."

6. MSMS should offer to assist the three components with medical schools in their counties to consider holding a "Day for Medical Students" to discuss activities and concerns of the components, of MSMS, and of the AMA.

7. The MSMS Ad Hoc Committee to Improve Membership should be continued and requested to meet from time to time to monitor developments and to offer other recommendations.

Component Society Activities

1. MSMS components should be requested to review MSMS Bylaws to speed up the membership transfer process.

2. MSMS components should be encouraged to review MSMS Bylaws to provide that (1) physicians-in-training may become active members with all the privileges of active members upon payment of a dues to be established locally by the component and upon paying one-half of the MSMS dues.

3. MSMS components should be requested to review MSMS Bylaws to provide for components to admit medical students as non-dues-paying, non-voting student members.

4. Components should be encouraged to set up procedures whereby the hospital staff lists in that component area can be coded to show which are members so non-members can be known and contacted.

5. Components should be encouraged to have an active standing committee on membership which should include a cross-section of members. Components may wish to identify one or more interested members on each hospital staff to function as members of the membership committee. Components further are encouraged to especially include young physicians and foreign-trained physicians on the membership committee.

6. Components should involve selected members in special efforts to encourage more physicians to belong to the AMA.

Here are first raw data in MSMS claims survey

By John H. Anthony
Manager, MSMS Bureau of Economics

This report displays in a preliminary fashion, the findings of the MSMS Bureau of Economics' collection and summarization of facts from Michigan malpractice insurance claims report forms. These forms have been gathered by the Michigan Medical Practice Board from 1975 to March, 1977.

A Michigan statute was passed in July, 1975 that requests malpractice insurance carriers to report the resolution of all claims and suits against their insureds. The Michigan Insurance Bureau collects the forms and provides copies to the Medical Practice Board. The Bureau of Economics was able to conduct this study through the cooperation of Bert Brennan, executive director, Michigan Medical Practice Board.

This report requires technical interpretation before any conclusions can be drawn, and distribution therefore will be limited. It is intended for use by actuaries, insurance companies, and other professional insurance people who may find the data useful when combined with other information.

Malpractice Insurance Claims Report

1. County:		
Wayne	217	40.0%
Oakland	61	11.2
Macomb	30	5.5
Genesee	25	4.6
Washtenaw	22	4.1
Upper Peninsula	8	1.5
Other counties	180	33.1
	543	100.0%

2. Type of Practice:		
Institution	17	3.2%
P.C. or partnership	121	22.8
Self-employed	373	70.4
Employed MD	19	3.6
	530	100.0%

3. Place of Injury:		
Hospital	362	67.8%
Emergency room	69	12.9
Outpatient clinic	14	2.6
Nursing home	1	.2
Physician's office	84	15.8
Patient's home	4	.7
	534	100.0%

4. Foreign Medical Graduate?		
Yes	90	17.4%
No	426	82.6
	516	100.0%

5. Type of Settlement:		
Before trial	292	55.8%
During trial	13	2.5
After trial but before verdict	1	.2
After judgment	24	4.6
Claim or suit abandoned	185	35.4
By review board	8	1.5
	523	100.0%

6. Settlement Date:		
Prior to 1976	177	34.1%
First quarter, 1976	87	16.8
Second quarter, 1976	109	21.0
Third quarter, 1976	46	8.9
Fourth quarter, 1976	79	15.2
First quarter, 1977	21	4.0
	519	100.0%

7. Specialty:

General surgery	113	21.4%
Obstetrics-gynecology	98	18.6
General practice — minor surgery	62	11.7
General practice	49	9.3
Orthopedic surgery	44	8.3
Internal medicine	21	4.0
Anesthesiology	19	3.6
Otolaryngology	18	3.4
Urological surgery	13	2.5
Pediatrics	10	1.9
Neurological surgery	10	1.9
Psychiatry	10	1.9
Thoracic surgery	8	1.5
Opthalmology	7	1.3
Emergency room medicine	7	1.3
Plastic surgery	6	1.1
All other	33	6.3
	528	100.0%

8. Physician's Age:

35 and below	52	10.3%
36-50	292	57.8
51-64	129	25.6
65 and above	32	6.3
	505	100.0%

9. Plaintiff's Average Age: 34.9 years; 73 were age 18 or below.

Type of Settlement	Number	Total Indemnity Paid	Average Cost	Average Payment To Defense Counsel
1. Before Trial	261	$5,183,535	$19,860	$ 1,563
2. During Trial	13	354,670	27,282	4,401
3. After Trial but Before Verdict	1	10,000	10,000	10,970
4. After Judgment	23	272,711	11,857	4,779
5. Claim or Suit Abandoned	165	1,515,534	9,185	1,113
6. By Review Board	8	68,000	8,500	7,889

Total Indemnity Paid — All Types of Settlements

0 - $5,000	280
$5,001 - $25,000	97
$25,001 - $100,000	41
$100,001 - $250,000	8
over $250,000	6

There were 170 claims and suits that had no dollar payout. This is 31% of the total reports on file.

When interpreting the data, special caution is necessary to avoid reaching inaccurate conclusions. For example, the reader should not conclude that general practitioners need to be placed in a higher risk category because of the number of claims against them; the size of the general practitioner population must be considered and compared.

Due to incomplete answers, the findings will not total the same for each specific data element.

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

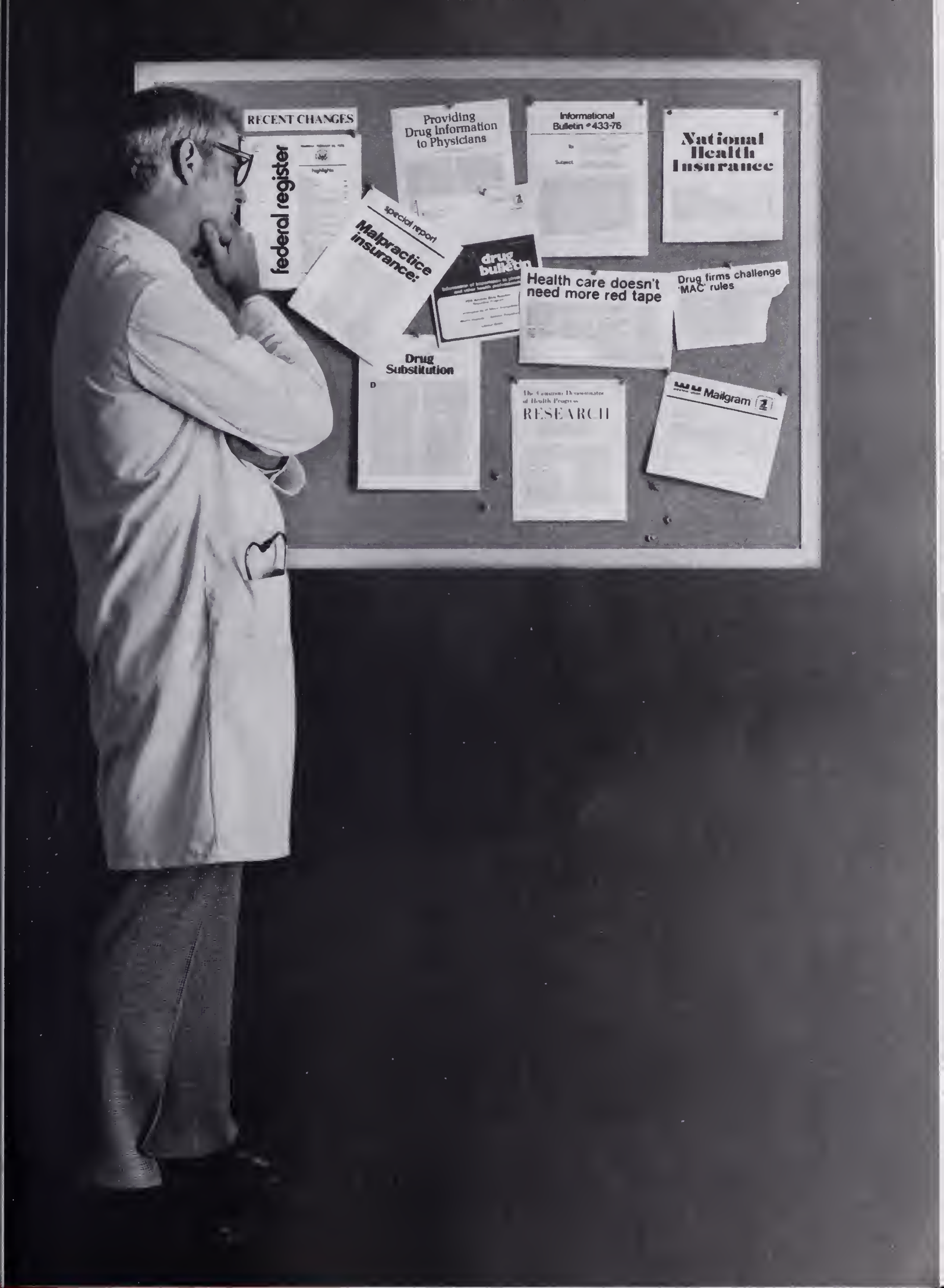
The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005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highlights
Providing Drug Information to Physicians
Informational Bulletin #433-76
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special report
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Health care doesn't need more red tape
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Before we go further with CME, we must consider these issues

By Floyd C. Pennington, PhD
Donald E. Moore, Jr., Ann Arbor

Accelerated technological and social change affects us all. Persons practicing in the medical profession are no exception. Increasing specialization, changes in work settings and professional relationships, as well as increasing sophistication and complexity of client systems are some of the outcomes of technological and social change. As these changes increase in rate and complexity initial medical training rapidly becomes inadequate, forcing practicing physicians to devise strategies to keep up with recent developments. Continuing medical education is one way that physicians deal with such changes.

Some persons who plan and conduct CME activities are concerned about the role that continuing education is expected to perform in minimizing occupational obsolescence and allegedly improving the quality of patient care. A vocal minority have used forceful arguments to advocate mandatory participation in CME as a requirement for recertification or relicensure. Medical professionals and legislators, acting as spokesmen for the public, as well as representatives of the medical profession have argued for the implementation of mandatory CME as a guarantee of competent medical practice.

The movement toward requiring physicians to attend and report their participation in approved CME activities is progressing without sufficient consideration of many critical issues. The purpose of this statement is to identify some of these issues. The issues are clustered around four role perspectives: the public, the profession, educators and individual physicians.

The Public

The public is demanding that quality medical care be available and delivered to all of its members. State governments, acting as agents of the public, are establishing regulations and relicensure laws that are supposedly designed to guarantee competent medical practice. This growing legislative involvement centers around increasing public concern about malpractice, stipulations for accountability in federal legislation, and the activities of consumer groups. Legislative bodies throughout the country are examining the question of competent medical practice and recommending laws that will provide safeguards for the public.

Some critical issues and questions which must be considered as a result of this public and legislative activity include:

(1) Is the public concerned about quality health care or complaining about the availability of health care services?

(2) Who is responsible for safeguarding the public against incompetent medical practice?

(3) Are adequate mechanisms available so that the public can be assured that adequate levels of competence are maintained by physicians? (Membership in a professional association? Certification by that association? Licensure by an agency of the state government? Performance testing? Mandatory CME? Competency-based relicensure?)

(4) What is the legality of combining any of the aforementioned as requirements for the right to practice?

(5) Is medical practice a right or a privilege?

(6) What kind of monitoring system should be established, if any, and how should it be administered? Who should keep records?

(7) Should all physicians be included and treated in the same way? (Older physicians? Younger physicians? Academics? Primary care physicians?)

(8) What is the relationship between monitoring medical practice and the enforcement of regulations concerning physician competence?

The Medical Profession

The medical profession shares the public's concern about physician competence. Questions and issues surrounding the problem of obsolescence, medical competence, quality patient care and mandatory continuing education from the perspective of the profession include:

(1) What is physician competence? What is continuing competence?

(2) What are the criteria and standards for competent as well as quality medical care? Can competence be measured? Who defines criteria and standards, persons internal or external to the profession?

(3) How long does it take before skills and knowledge attained in medical education become obsolete? Is educational half-life a realistic concept?

(4) Should efforts be made to maintain standards which would be

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Mr. Moore is director of education, Veterans Administration Hospital, Ann Arbor.

a desirable ceiling for all to aspire to or a floor for a few?

(5) How does disagreement within the profession about theories and approaches to medical practice affect the definition of professional competence and quality patient care?

(6) What is the relationship between the definition of competence and requirements for licensing, membership or certification? What role should continuing medical education have in these deliberations?

Educators

An increasing number of educators are becoming involved in CME. The following questions highlight some of the educational issues related to mandatory continuing education.

(1) Can continuing medical education or any kind of education *guarantee* competent health care delivery? What is the relationship between knowing and doing?

(2) Can *mandatory* continuing education for physicians *guarantee* competent practice? Do *all* physicians *need* continuing medical education? How will mandatory attendance affect the learning of those who would not normally attend voluntary sessions?

(3) What is the purpose of mandatory continuing medical education?

- (a) Is it an alternative way for professional associations to monitor and measure the competencies of their members?
- (b) Is it a transition phase to some other system of professional accountability?
- (c) Does it serve only as a public relations function for professional associations, individual physicians and universities?
- (d) Is it conceived as only one of may inputs into a system designed to guarantee adequate levels of physician performance?

(4) As mandatory continuing education becomes a reality, what are the educational delivery capabilities of present continuing education structures?

- (a) What is the supply of resource people? Is the cost/benefit ratio for the time and effort of the resource person worthwhile?
- (b) Are there strong institutional commitments by sponsoring organizations to provide continuing education for physicians?
- (c) What institutional arrangements within and among sponsors will be necessary for effective continuing education activities for physicians?
- (d) What are the implications of continuing education for medical schools? Specialty societies? Community hospitals?
- (e) Should mandatory continuing education for physicians be competency-based and assessed in performance terms?
- (f) Who will select content and how will it relate to physician competency and identified deficiencies?

(5) How can procedures that have been developed for adult and continuing education generally contribute to the success of mandatory continuing education for physicians?

- (a) What are important considerations for planning? How should practicing physicians participate in planning? How can different programs be developed for different levels of medical practice? How do constraints of time and practice affect the physician's participation and performance in mandatory continuing education programs?
- (b) What kinds of instructional formats are effective? What combinations of educational delivery systems can be developed to accommodate the self-directed learner and individual preference?
- (c) How can the educational needs of physicians be identified? Do physicians need counseling to identify these needs and choose the most effective educational experience? Will physicians be permitted to select activities most appropriate to personal needs?
- (d) How will mentors be chosen? Who will select them? What will be important qualifications? What rewards will be offered vis-a-vis their own continuing education requirements?
- (e) Who will sponsor mandatory continuing education for physicians and what will be the responsibilities of sponsorship?
- (f) Who will provide administrative support? Who will provide support staff? Should they have special training?
- (g) Who keeps records? Is the Physician Recognition Award adequate? Will credit be awarded for attendance or knowledge gained?
- (h) How can programs be evaluated to assess change in patient care as a result of continuing education participation?
- (i) How do planners guarantee continuity of activities and a comprehensive program for all participants?

(6) Should universities take a leading role? What is the role of continuing educators? How can interinstitutional, interorganizational and interprofessional collaboration be attained to address the problems of providing continuing education for physicians?

The Individual Physician

The person most affected by the requirements for mandatory continuing education is the practicing physician. Some of the issues that concern practicing physicians include:

CME/*Continued*

(1) Are all approval groups accepting and approving the same kinds of activities? What kinds of activities will count?

(2) How many contact hours per year are required for each physician? Who determines the amount? What is the basis for determining this amount?

(3) What is the cost/benefit ratio for a physician with respect to his or her practice?

(4) Does mandatory continuing education represent a significant erosion of leisure time and invasion of personal life?

(5) Who will pay for participation in mandatory continuing education activities? Will cost include the loss of practice time in addition to tuition, fees, materials, travel and lodging? Will the individual physician be required to pay? Will the state pay? Will the public pay in the form of increased fees?

(6) Where will these activities take place? How inconvenient will location be for practitioners? Will special considerations be given to geographically isolated physicians? Will cost of travel be prohibitive? Should the medical profession develop a regional approach?

(7) How will specialization be taken into account? Will courses and exams be focused on each specialty or will specialists be forced to deal with content outside their areas of practice?

Conclusion

Whether or not continuing education becomes mandatory in all states or in just a few, these are some of the issues that persons responsible for planning and conducting continuing education activities and programs for physicians will have to recognize and deal with.

Recent research indicates that in the health professions, participation rates in continuing education are low, reflecting a feeling that continuing education is not an effective approach for dealing with problems of professional competence and obsolescence.[1]

Poor educational planning is identified by the authors of this research as the major factor contributing to low participation levels.

One way to correct this situation might be to concentrate efforts on providing quality programs for those physicians who do participate. These individuals are generally opinion leaders and their continued attendance at quality programs might influence their colleagues to attend or inquire about what material was learned at the meeting. Mandatory continuing education may sacrifice quality for quantity.

Another approach centers around efforts of individuals and groups with responsibilities for continuing medical education to determine collectively who can most effectively deal with the interrelated problems of professional competence, occupational obsolescence, and quality professional services.

For example, **university or college administrations** should agree to facilitate continuing education for physicians by providing the necessary institutional commitment and faculty rewards. **Continuing education divisions** working with medical schools should assume major responsibilities in providing continuing education for physicians and other health care professionals. These responsibilities would consist of coordinating the activities of several groups and providing leadership in program development, program management, and coordination. **Medical schools** should deal with subject matter and related research. Some medical schools have combined within their own administrative structures total responsibility for all aspects of CME.

The **public** is responsible for maintaining appropriate pressure on the medical profession, educational institutions and legislative bodies which will result in actions assuring them of access to competent health care services. Citizens must also assume responsibility for active participation as individuals and with groups in shaping policy decisions related to physician competence. The individual's ultimate responsibility is to maintain his own personal health.

The **government** must lead and be responsive to the public and the profession. Legislative actions concerning physician competence must be carefully structured. Linking physician competence to participation in continuing education and enforcing this by legislative mandate must be defensible.

Professional societies should develop standards for medical practice, identify competencies connected with those standards, and establish criteria to ascertain the extent to which their members possess these competencies. These actions, however, must not be taken in isolation.

The **individual physician** should assume personal responsibility for maintaining his own competence. He must also assume responsibility for selecting effective ways, including continuing medical education, to stay current and extend himself within the profession. Each physician must also assume some measure of corporate responsibility for the quality of health care delivery provided by other members of the profession.

There is a danger that the current concentration on discussing the merits of mandatory vs. voluntary continuing education might obscure the fact that continuing medical education must be considered as only one part of a larger system that is addressing public concerns about competent health care delivery.

Continuing medical education can contribute to the improvement of patient care, but it can guarantee nothing. A belief that continuing education serves this singular purpose will end in less than satisfactory results. A belief that one group acting in its own self interest can transform health care delivery through continuing education is impossible.

The issues raised in this brief statement demand the serious commitment of a variety of people working together on a problem of critical national importance.

Reference

1. June Nakamoto and Coolie Verner, "Continuing Education for Health Professions," Syracuse, ERIC, 1973.

Just what the doctor ordered . . .
MICHIGAN STATE FOOTBALL!

Quarterback Eddie Smith (7), the Big Ten's leading passer and total offense leader last year.

Your prescription for exciting fall entertainment is six Saturdays in 76,000-seat Spartan Stadium.

The pass-happy and daring Spartans offer you a refreshing alternative to dull, grind-it-out football. Under innovative Head Coach Darryl Rogers, Michigan State is forging one of the most explosive and exciting teams in the Big Ten, featuring the league's top passer and total offense leader and the leading pass receiver.

Six home games are on tap, and with season tickets, you'll see them all. There are intersectional clashes with Washington State, boasting the nation's No. 1 returning passer, and Wyoming, 1976 Fiesta Bowl participant. And there are four always-tough Big Ten contests with conference champion Michigan and Purdue, Illinois and Northwestern.

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Add to this the color and pageantry of Band Day and Homecoming Day, fine music by the 255-member Spartan Marching Band, the cheerleaders and the Spartan Spirit Block card section, and convenient parking where you can enjoy a tailgate picnic both before and after the game, and you have a few of the alternatives for six fun-filled fall football Saturdays.

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SEASON TICKET APPLICATION

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MM

Category I Courses

Michigan Medicine *each month will carry a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of the new Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing will indicate a contact person, so the physician can obtain details. The list will be expanded as courses are developed by accredited sponsors. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.*

The following have been accredited by MSMS Commission on Continuing Medical Education:

Organizations:

Ann Arbor Psychiatric Association
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Society of Anesthesiologists
University of Michigan School of Public Health

Hospitals:

Alma-Gratiot Community Hospitals, Alma
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med.Center, PC/Little Traverse Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Detroit-Macomb Hospital Association
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Henry Ford Hospital, Detroit
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo State Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital), Muskegon
Marquette General Hospital
McLaren General Hospital, Flint
Mercy Hospital, Port Huron
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Oakland Medical Center, Pontiac
Oakwood Hospital, Dearborn
Pontiac General Hospital, Pontiac
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Edward Sparrow Hospital, Lansing
Traverse City State Hospital, Traverse City
V. A. Hospital, Battle Creek
Wayne County Psychiatric Hospital, Eloise
West Shore Hospital, Manistee
Ypsilanti State Hospital, Ypsilanti

Date: June 15-24, Advanced Institute in Methods of Immunological Diagnosis. Location: Cranbrook Educational Community, Bloomfield Hills. **Sponsor:** Wayne State University School of Medicine. **For:** All interested physicians. **Cost:** $600. **Contact:** Noel R. Rose, MD, PhD, Department of Immunology and Microbiology, WSU, 540 East Canfield, Detroit 48201. **Approved for:** 60 hours of Category I credit.

Date: June 17-18, Michigan Thoracic Society Annual Meeting, with American College of Chest Physicians, Michigan Chapter. Location: Kalamazoo Hilton Inn. **Sponsor:** Michigan Thoracic Society and Michigan Lung Association. **For:** All specialties. **Cost:** None. **Contact:** Tom Sovine, Michigan Lung Association, 403 Seymour Ave., Lansing, 48914. **Approved for:** 9 hours of Category I credit.

Date: June 17-19, Advances in Cardiac Life Support — Instructors Course. Location: Henry Ford Hospital, Detroit. **Sponsor:** Michigan Heart Association and Henry Ford Hospital. **Co-sponsor:** American College of Emergency Physicians and Comprehensive Health Planning Council of Southeastern Michigan. **For:** All cardiac life support instructors. **Cost:** $250. **Contact:** Dennis Hampton, Michigan Heart Association, (313) 557-9500. **Approved for:** 24 hours of Category 1 Credit.

Date: June 20-24, Northern Michigan Summer Conference. Location: Shanty Creek Lodge, Bellaire. **Sponsor:** Office of Continuing Education, Dept. of PGM/HPE. **Cost:** $200. **Contact:** Office of Continuing Education, Dept. of PGM/HPE, U. of M.*. **Approved for:** 22 hours of Category I credit.

Date: June 22, Carcinoma of the Thyroid. Location: Grace Central Hospital, Detroit. **Sponsor:** WSU School of Medicine, Dept. of Oncology. **For:** All interested physicians. **Cost:** $20. **Contact:** Dorothy Bewley, (313-494-6025), 4160 John R, Detroit, Mi 48201. **Approved for:** 2½ hours of Category I Credit.

Date: June 23-25, Macular and Retinal Vascular Disease Conference. Location: Henry Ford Hospital. **Sponsor:** Henry Ford Hospital, Detroit Institute of Ophthalmology, Bon Secours Hospital. **For:** Ophthalmologists. **Cost:** $200 for practicing physicians, $100 for residents and fellows. **Contact:** Judy Dara, Detroit Institute of Ophthalmology, 15401 E. Jefferson, Grosse Pointe Park, 48230 (313)824-4800. **Approved for:** 16 hours of Category I credit.

Date: July 21-24, "The Psychiatrist and the Public Mental Health System." Location: Boyne Mountain Resort, Boyne Falls. **Sponsor:** Michigan Psychiatric Society. **For:** Psychiatrists. **Cost:** MPS Member $70, Non-Member $100, Member-in-Training, $30. **Contact:** Emmanuel R. Casenas, MD, Program Chairman, 32905 W. 12 Mile Road, Farmington, 48024. **Applied for:** 8 hours of Category I Credit.

(Continued on page 312)

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2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
Final classification of the less-than-effective indications requires further investigation.

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Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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CATEGORY I/*Continued*

Date: July 26-28, Summer Meeting. Location: Bay Valley Inn, Bay City. **Sponsor:** Michigan Chapter, American Academy of Pediatrics. **For:** Pediatricians. **Cost:** $30 member, $50 non-member, $10 resident. **Contact:** Miles Tiernan, Executive Secretary, MCAAP, (313) 553-3646. **Approved for:** 7 hours of Category I Credit.

Date: July 28-29, Annual Coller-Penberthy-Thirlby Medical Conference. Location: Park Place Motor Inn, Traverse City. **Sponsor:** Munson Medical Center, Traverse City. **For:** All specialties. **Cost:** None. **Contact:** Kenneth H. Musson, MD, Grand Traverse Ophthalmology Clinic, PC, 1105 E. Front St., Traverse City, 49684. **Approved for:** 9 hours of Category I credit.

Date: Aug. 6-10 — Annual Meeting and Scientific Program. Location: Sugar Loaf Resort, Cedar. **Sponsor:** Michigan Academy of Family Physicians. **For:** Family Physicians. **Contact:** Rita Feldkamp, MAFP executive secretary, 933 Wing St., Plymouth, 48170. **Approved For:** 28½ hours of Category I credit.

Date: Aug. 13-14, AMA Regional CME Program. Location: Northern Michigan University, Don Bottom Conference Center, Marquette. **Sponsor:** American Medical Association. **For:** All specialties. **Cost:** Prices for five courses, $70; Advanced CPR, $160. **Contact:** Gale Jewitt, AMA, (312) 751-6570. **Approved for:** 6 hours of Category I credit, 14 for advanced CPR.

Date: Oct. 8, Clinical Day on "Low Back Pain." Location: Inservice Classrooms, Holy Cross Hospital, 4777 E. Outer Drive, Detroit. **Sponsor:** Holy Cross Hospital Medical Staff Education Committee. **For:** All specialities. **Cost:** $25. **Contact:** Kenneth K. Newton, M.D., Director of Medical Education, (313) 369-9100, ext. 2355. **Approved for:** 6 hours of Category I Credit.

Date: October 12, Diseases of the Breast. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **Cost:** $50. **Contact:** Department of CME, St. John Hospital, (313) 881-8200, ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 22, "Manifestations of Systemic Diseases in Sub-Specialties." Location: Inservice Classrooms, Holy Cross Hospital, 4777 E. Outer Drive, Detroit. **Sponsor:** Holy Cross Hospital Medical Staff Education Committee. **For:** All specialties. **Cost:** $25 for staff members; $35 for non-staff members. **Contact:** Kenneth K. Newton, MD, Director of Medical Education, (313) 369-9100, ext. 2355. **Approved for:** 6 hours of Category I Credit.

Date: November 8-10, MSMS Annual Scientific Session. Location: Hyatt Regency Dearborn. **Sponsor:** MSMS Committee on CME Programming. **For:** All specialties. **Contact:** Herbert Auer, MSMS Department of CME Programming. (517) 337-1351.

Continuing Courses

Date: Monthly, Ob/Gyn Journal Club. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** All interested physicians. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Monthly Urology Journal Club; Location: Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Urologists; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital****; **Approved for:** 2 hours of Category I Credit.

Date: Continuing Quarterly Journal Club — Surgery; Location: Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Surgeons; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Monthly, Cleft Palate Clinic. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital****. **For:** Oral Surgeons, plastic surgeons, pediatricians. **Cost:** None. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 3 hours of Category I Credit.

Date: Monthly, Tissue Audit (Cancer). Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Surgeons, ob-gyns, pathology, radiology. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 2 hours per session Category I Credit.

Date: Monthly Lecture Series in Ophthalmology; Location: Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Ophthalmogists; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Every Tuesday — Psychiatry — Special Problems Seminar; Location: Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Psychiatrists; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital****; **Approved for:** 2 hours of Category I Credit.

Date: Every Tuesday morning, Gynecology/Obstetrics Combined Grand Rounds. Location: Jackson Auditorium, Hutzel Hospital. **Sponsor:** Wayne State University Department of Gynecology-Obstetrics. **For:** All interested physicians **Cost:** No charge. **Contact:** Wayne State University, Division of CME**. **Approved for:** 4 hours each of Category I Credit.

Date: Wednesdays, Sept. 14 - Nov. 16, Cardiology Seminars. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** All specialties. **Cost:** $200. **Contact:** Department of CME, St. John Hospital, (313)881-8200, ext. 321. **Approved For:** 2 hrs per session hours of Category I Credit.

Date: Thursdays, Sept. 15 - Nov.17, Nuclear Medicine in Clinical Practice. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** All Specialties. **Cost:** $200. **Contact:** Department of CME, St. John Hospital, (313)881-8200, ext. 321. **Approved for:** 2 hrs per session hours of Category I Credit.

Date: Each Wednesday, Detroit Medical Center Hand Conference. Location: Classroom 3, Second Floor, Webber Wing, Harper Hospital, Detroit. **Sponsor:** Wayne State University. **For:** Surgeons. **Cost:** No charge. **Contact:** Joseph L. Posch, MD, Fourteenth Floor, Kales Building, 76 W. Adams, Detroit 48226. **Approved for:** Hour-for-hour Category I credit.

Date: Second Thursday of each month, Inter-Hospital Pathology Slide Conference. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** Pathologists. **Cost:** No charge. **Contact:** Department of CME, St. John Hospital, 22101 Moross Road, Detroit, 48236, (313) 881-8200. **Approved for:** 3 hrs. each date Category I Credit.

Date: Saturdays, Morbidity and Mortality Conference. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital Department of Surgery. **For:** Surgeons. **Cost:** None. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 2 hours of Category I Credit per session.

Date: Every Saturday, Weekly Conference. Location: Gamble Building, Burns Clinic/Little Traverse Hospital, Petoskey. **Sponsor:** Burns Clinic/Little Traverse Hospital. **For:** All interested physicians. **Cost:** None. **Contact:** Ernest W. Carpenter, MD, 560 West Mitchell, Petoskey, 49770.

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*Office of Intramural Education, University of Michigan Medical Center, Dep't. of PGM/HPE, Ann Arbor, 48109

**WSU Division of CME, Room 1209, Scott Hall, 540 E. Canfield, Detroit, 48201 (313) 577-1453

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902

****Department of CME, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 272-6000

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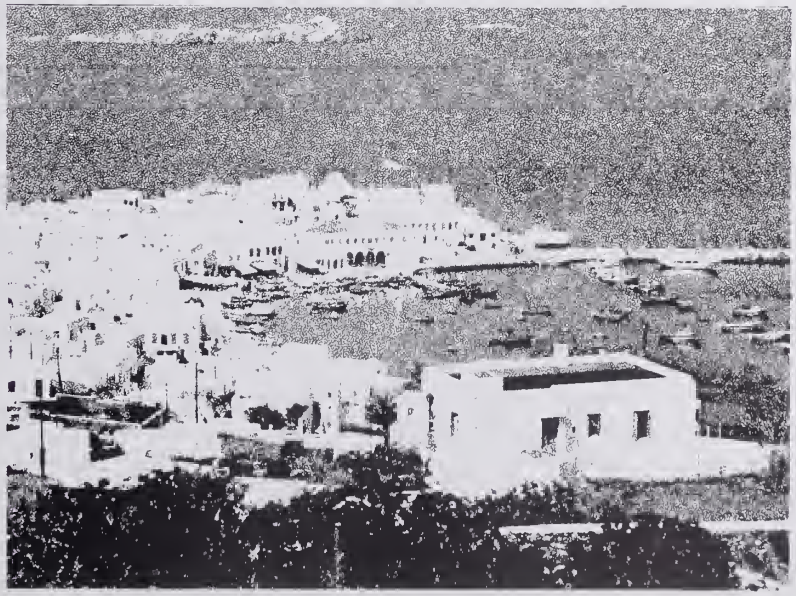

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Senator Geake, psychologist, now key public health figure

By Gene Hashley
Special to **Michigan Medicine**

When Senator Bob Geake is given a job to do, he takes it seriously. But then, Bob Geake is a serious person.

"I'm very concerned about the lack of physician services in rural areas," he says, by way of example. "I believe the legislature will have to do something to encourage or stimulate the availability of the full range of medical services in the more sparsely populated areas of the state," Geake said.

He adds that he feels the legislature should look to the traditional ways of providing additional scholarships and internships as means of stimulating the number of general practitioners.

"Like many other legislators, I am deeply concerned that every citizen of the State of Michigan has access to adequate health care."

He currently is a member of the Michigan Senate Health, Social Services and Retirement Committee and prior to that served as Republican Vice-Chairman of the House Public Health Committee for two years.

Until beginning his legislative career, Geake spent his professional life in the mental health field — first as school psychologist and coordinator of child development at Greenfield Village Schools and later as supervisor of outpatient psychological services at the Plymouth State Home and Training Center at Northville. He was later promoted to director of the Psychology Department and was serving as director of programs — when he resigned to seek election to the legislature.

Geake authored the legislation permitting the establishment of HMO's in Michigan and is a staunch supporter of the new Public Health Code. He served as a member of the Public Health Statutes Revision Project (PHSRP) and was a leader during House floor debate on the code in 1976.

Senator Geake feels the new code solves many problems including the problem of determining which health care professions should be regulated by the state and to what extent.

"There's no question that we need to license physicians — it's absolutely necessary. While I certainly would not advocate adding any additional red tape to the health profession at this time, I am concerned about the growing number of paraprofessional groups that are coming to the legislature seeking licensure.

The following article is the second in a series. The articles, written especially for *Michigan Medicine* by Lansing free-lancer Gene Hashley, profile Michigan legislators who are key figures in the formulation of health care legislation and programs.

Senator Geake

"In many cases licensing may not be needed, although certification may be desirable."

To facilitate the availability of a full range of health care services, Geake believes there is a need for a wide range of health professionals with varying degrees of training.

"Certainly chiropractors have an important role to play in the overall provision of health care services," Geake says. He sponsored the amendments to the Public Health Code when it was being considered by the House in 1976 to more clearly define the chiropractic scope of practice.

The Senator views the Medicaid program as a program with three major problems — fraud, abuse and excessive paperwork.

"In fact, there are such great opportunities for abuse there is little incentive left for outright fraud, in my opinion.

"I think we have to be concerned about the cost of the Medicaid program, especially when we are losing between $80 million and $100 million a year through abuse and fraud. It is especially alarming that last year, for the first time, the cost of the Medicaid program actually exceeded the cost of ADC," he said.

Geake feels more common sense and fewer bureaucrats in the Department of Social Services could probably reduce the unnecessary paperwork both for the Department and the providers. He feels there are many things the legislature can and must do to stop abuses.

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References:

1 Dornfeld L, Kane R. Metolazone in essential hypertension. The long-term clinical efficacy of a new diuretic. *Curr Ther Res* **18:** 527-533, 1975

2 Data on file, Medical Department, Pennwalt Prescription Products

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Brown-McNeely Fund is a state agency; here's what that means to physicians

By Monte Jahnke
Detroit

Michigan Attorney General Frank J. Kelley, issued his second opinion concerning the Brown-McNeely Insurance Fund on March 24, 1977. This opinion (No. 5156) supplements opinion number 4934, dated May 5, 1976 which found the fund to be a state agency. Since issuance of the March 24th opinion, the attorney general has written Brock E. Brush, MD, chairman of the fund, to clarify that portion of the opinion which concerns the use of assistant and special assistant attorneys general as the only legal counsel permitted to represent Brown-McNeely insureds in court.

This article briefly summarizes the most important aspects of the March 24 opinion. The 10 basic conclusions reached in that opinion are:

1. The Brown-McNeely Insurance Fund is a state agency in the executive branch within the Department of Commerce.

2. Employees of the Brown-McNeely Insurance Fund are within the state classified civil service.

3. The Brown-McNeely Insurance Fund is a state agency subject to the provisions of the Michigan Administrative Procedures Act.

4. Unless exempt from disclosure by law, records of the Brown-McNeely Insurance Fund are public records.

5. Meetings of the board of directors of the Brown-McNeely Insurance Fund are subject to the provisions of the Public Meetings Act.

6. Officers and employees of the Brown-McNeely Insurance Fund are subject to the provisions of the State Board of Ethics Act.

7. The board of directors of the Brown-McNeely Insurance Fund may not employ legal counsel other than the attorney general.

8. The funds of the Brown-McNeely Insurance Fund are trust funds which may only be used to pay losses and expenses of the fund; the assets of the fund may not be placed in the general fund by the legislature.

9. The legislature did not intend the Brown-McNeely Insurance Fund to follow the process of obtaining an appropriation for its operation that other state agencies are required to observe.

10. Neither the state, the commissioner of insurance, nor any other state officer is liable or responsible for payment of claims made against the Brown-McNeely Insurance Fund.

This list of findings by no means answers all of the unresolved questions that have been asked during the past two years concerning the fund and particularly interpretation of its implementing act (1975 Public Acts No. 43). The principal questions being asked by physicians and insurance companies in Michigan still surround the assessment feature of the act in particular.

This most recent opinion does little to clarify rights and responsibilities of doctors and their insurers should an assessment be required. The opinion does, however, contain findings which make it clear that the attorney general understands the Fund to be entirely independent of state fiscal resources, particularly appropriation funding.

State Agency Characteristics

Findings one, two and three of Opinion 5156 serve to complete the state agency status granted the Brown-McNeely Fund by the attorney general's May 5, 1976 opinion. The conclusion that the fund is within the Department of Commerce under the executive branch clarifies the status of the Fund within the total scheme of state government.

The determination of civil service status (Finding No. 2) and the application to the fund of the Michigan Administrative Procedures Act (Finding No. 3) are consistent with the finding of state agency status.

The Attorney General's conclusion that the fund is subject to the Administrative Procedures Act appears to be more a matter of housekeeping than anything else. The initial legislation which created the fund cited Administrative Procedures Act requirements concerning the promulgation of rules and appeals to the Commissioner of Insurance. The March 24, 1977 Opinion obviates any question concerning whether any other aspects of the Administrative Procedures Act apply to the Brown-McNeely Fund.

Mr. Jahnke is an attorney in the office of A. Stewart Kerr, Detroit, MSMS legal counsel.

BROWN/McNEELY/*Continued*

Disclosure Requirements

Application of the Administrative Procedures Act to the Brown-McNeely Fund makes the records of the fund subject to wide disclosure in the opinion of the Attorney General. The opinion refuses to differentiate between "public functions" and "insurance functions" of the Fund as apparently understood by its Board. It goes on to cite certain Michigan authorities advocating wide disclosure and it specifically quotes Sections 21 and 22 of the Administrative Procedures Act dealing with public disclosure of records kept by state agencies, and exceptions thereto. There are six basic exceptions found in Section 22. The most important of these for Michigan doctors insured by the Fund is that which prohibits disclosure where confidential or privileged information would be compromised. This is essentially the same protection guaranteed by the general law to physician records.

A concomitant requirement of public disclosure is the finding that the fund is subject to the Public Meetings Act (No. 5). The Attorney General has opined that the Brown-McNeely Insurance Fund Board is a "public body" as defined in the Public Meetings Act, and that such a finding is not inconsistent with that portion of the Brown-McNeely statute which requires annual meetings and notice to Fund members and all eligible providers of such meetings. Many if not all of the Brown-McNeely Fund board meetings have been open to the public in the past. Finding No. 5 guarantees that they will remain so.

The sixth listed finding of the March 24th opinion concludes that the State Board of Ethics Act is applicable to officers and employees of the Brown-McNeely Insurance Fund. This is important because that act contains several specific controls upon the activities of public officers and employees. Among its requirements is the strict avoidance of conflicts of interest.

Representation By Attorney General's Office Only

Opinion No. 5156 concludes that it would be improper for the Brown-McNeely Insurance Fund to be represented by other than Special Assistant Attorneys General. This finding is based upon the previous conclusion that the fund is a state agency. As the state's exclusive source for legal representation, it is the attorney general's office and its delegates who must have the right to represent the fund in court and otherwise according to the March 24 opinion.

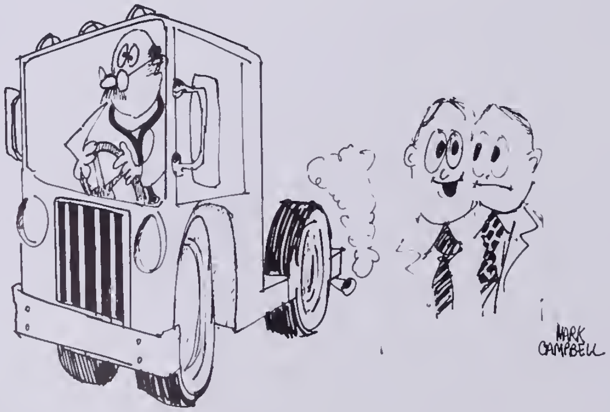
On April 26, 1977, Attorney General Kelley wrote to Doctor Brush to clarify that portion of the March opinion requiring representation by the Attorney General only. Brown-McNeely defense files now in the hands of outside counsel will be concluded by such counsel, according to that letter. Subsequently, the Attorney General intends to appoint selected attorneys (probably private firms) as special assistant attorneys general for the handling of such claims. The past Brown-McNeely practice of directly retaining private attorneys to defend its insureds will consequently cease. Any such assignments will be made under the auspices of the attorney general's office.

Fiscal Independence

Findings eight, nine and ten place the Brown-McNeely Fund squarely on its own insofar as fiscal operations are concerned. Finding eight requires that the legislature respect this independence by not mixing Brown-McNeely monies with the state's general fund. This is a necessary corollary to finding nine which excludes the Brown-McNeely Fund from participating in the appropriation scheme of state government. The Attorney General has concluded that the Fund was created to depend on its own assets and to meet its liabilities independently of any state governmental funds. The assessment feature of the Act is to be used in making up any deficit. There are many questions remaining concerning the mechanics of any such assessment but it is at least clear from the Act that such an assessment would flow against all insured practicing physicians in the state and not only against those who are past or present insureds of the fund.

This is particularly important in light of the last of Attorney General Kelley's March 24, 1977 findings concluding that the payment of claims against the Brown-McNeely Insurance Fund cannot under any circumstances be levied against the state, the Commissioner of Insurance, nor any other state officer.

The attorney general's opinion then has the effect of foreclosing each and every avenue of financial aid to the fund with the exception of collected premiums and the assessment feature. If severe Brown-McNeely Fund deficits arise, the fund board will be left with no recourse but to assess doctors.



That's the Doctor. He joined the Teamsters in order to get weekends and holidays off.

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Meetings

June 13-17 — Speech, Language and Hearing Problems of Older Persons: Identification and Management, Ann Arbor, contact: Dorothy H. Coons, Director of Cont. Ed., The Institute of Gerontology, The University of Michigan — Wayne State University, 520 East Liberty, Ann Arbor, Michigan 48109.

June 18-22 — AMA Annual Convention, San Francisco, contact: Warren Tryloff, MSMS Director.

July 10-13 — "A Sub-System Within the Health Care Delivery System," sponsored by Continuing Education, School of Public Health, University of Michigan, contact: Anna B. Brown, Ph.D., Director of Continuing Education, 3550 School of Public Health I, The University of Michigan, 109 S. Observatory Street, Ann Arbor, 48109.

July 11-22 — Biology of Aging, Ann Arbor, contact: Dorothy H. Coons, Director of Cont. Ed., The Institute of Gerontology, The University of Michigan — Wayne State University, 520 East Liberty, Ann Arbor, 48109.

July 18-21 — Medical Office Management Institutes (MOMI), sponsored by Conomikes Associates, Inc., Hospitality Motor Inn, Lansing, contact: Conomikes Associates, Inc., 4270 Promenade Way, Suite 122, Marina del Rey, CA, (213) 823-4661 or call TOLL FREE (800) 421-6512.

July 22-24 — MSMS Council, Deer Lake, Boyne Falls, Michigan, contact: Warren Tryloff, MSMS Director.

July 24-29 — "Supervision in the Health Field: Theory, Process, Practice," sponsored by Continuing Education, School of Public Health, University of Michigan, contact: Anna B. Brown, Ph.D., Director of Continuing Education, 3550 School of Public Health I, The University of Michigan, 109 S. Observatory Street, Ann Arbor, 48109.

August 6-10 — Annual Convention and Scientific Assembly of the Michigan Academy of Family Physicians, Sugar Loaf Mountain, contact: Rita Feldkamp, executive secretary, MAFP, 933 Wing Drive, Plymouth, 48170.

August 7-12 — "Problems in Planning and Evaluation," sponsored by Continuing Education, School of Public Health, University of Michigan, contact: Anna B. Brown, Ph.D., Director of Continuing Education, 3550 School of Public Health I, The University of Michigan, 109 W. Observatory Street, Ann Arbor, 48109.

September 5 — MSMS/INTRAV Around-the-World Adventure, contact: Marce Ireland, MSMS headquarters.

September 7 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS Director.

September 12 — MSMS/INTRAV Orient Adventure, contact: Marce Ireland, MSMS headquarters.

September 17 — Michigan Society of Pathologists September Seminar, "Renal Disease," St. John Hospital, Detroit, Michigan, contact: John F. Dunkel, MD, Department of Pathology, MSU, East Lansing, 48823.

Sept. 29-Oct 1 — Category II course, "Implant Surgery for Joints and Tendons in the Hand," at Blodgett Memorial Medical Center, Grand Rapids, $200 fee, contact: Alfred B. Swanson, MD, 1900 Wealthy St., Suite 290, Grand Rapids, 49506.

November 2 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS Director.

November 8-9-10 — MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Herb Auer, MSMS headquarters.

December 14 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS Director.

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"Certainly more exploration . . . needs to be encouraged."

I reviewed the article you forwarded to me regarding factors which affect the length of stay as developed by Blue Cross and Blue Shield. I feel the data that they have uncovered is most interesting and probably is accurate, especially where it reflects that surgical admissions admitted on the weekends wait almost three days longer in the hospital for surgery. This probably varies greatly between hospitals.

In this day and age, when all of us are extremely cost conscious about the continuing escalation of the costs of medical care, I do not feel that this type of information can be ignored or "swept under the rug" by the medical community. Certainly more exploration of this matter needs to be encouraged and perhaps a larger study of other hospitals would be indicated.

Certainly this information needs to be brought to the attention of the membership of the State Medical Society so that all of us can do our part in attempting to hold down the rapidly escalating costs of medical care.

We must "keep our own house in order" or others will attempt to do it for us.

Sincerely yours,

Daniel J. Wilhelm, MD
Pediatric Associates of Port Huron

" . . . physician's assistant may prescribe a drug . . . as a delegated act of the supervising physician . . . "

This letter is in reference to the April, 1977 issue of *Michigan Medicine*. On page 218 in the article entitled "Tips for drug control by Michigan Physicians" it states that physicians' assistants and nurses are not licensed to prescribe drugs.

May I refer you to Act No. 420, Public Acts of 1976 (House Bill No. 6080) signed in February, 1977, by Governor Milliken. It states in section 17, paragraph 3: "A physician's assistant, may prescribe drugs as a delegated act of a supervising physician, but shall do so only in accordance with procedures and protocol for such prescription established by the (medical and osteopathic) boards in rule. Until these rules are promulgated, a physician's assistant may prescribe a drug other than a controlled substance as a delegated act of the supervising physician. . . ."

Your journal is well written and strives to address itself to the needs of your members. I am surprised you have made no mention in recent months of the progress of PA legislation in Michigan, either pro or con. The PA concept is of interest to both family practitioners and many specialists. Your journal would be the only reliable source of information for many Michigan physicians having an interest in recent PA legislation.

John Kircher PA-C

". . . in reference to physicians' assistants . . ."

In your April edition an article titled "Tips for drug control by Michigan physicians" quoted the MSMS Committee on Alcohol Abuse and Drug Dependency as follows: "Physicians' assistants and nurses are not licensed to prescribe drugs. To permit them to do so is a violation of the law."

This statement is erroneous in reference to physicians' assistants and bears correction. State of Michigan Public Act 420 of 1976 specifically states, "A physician's assistant may prescribe drugs as a delegated act of a supervising physician, but shall do so only in accordance with procedures and protocol for such prescription established by the boards in rule. Until these rules are promulgated, a physician's assistant may prescribe a drug other than a controlled substance."

The newly created Physicians' Assistant Committee of the State Board of Licensing and Regulation is currently in the process of granting the approval to individual qualified physicians' assistants which will allow them to legally prescribe drugs under this act.

I hope that both Mr. Streiff of the Drug Enforcement Administration and the Michigan State Medical Society will adjust their guidelines accordingly.

Sincerely,

Kenneth L. Klegon, PA
President
Michigan Academy of Physicians' Assistants

(Editor's note: Michigan Medicine *readers have been kept up to date on the new Michigan physicians' assistant legislation through news items in the Jan. 7 and March 11 issues of the* Medigram *newsletter.* Medigram *is published as a part of* Michigan Medicine *and goes to all journal subscribers. We thank Mr. Kircher and Mr. Klegon for their elaborations on the original article.)*

(Continued on page 326)

Coller-Penberthy-Thirlby meeting July 28-29

The 57th annual Coller-Penberthy-Thirlby Medical Conference of the Munson Medical Center, Traverse City, is scheduled July 28-29 at the Park Place Motor Inn in that city.

The scientific program selected by James A. French, MD, University of Michigan, will offer an update of medical advances for all specialties. Scientific papers will be presented by 30 physicians.

The meeting is named for Frederick Coller, MD, of the University of Michigan Medical School, who first began an informal postgraduate course in Traverse City in 1920; for Grover Penberthy, MD, of Wayne State University School of Medicine, who joined the faculty in subsequent years, and Edwin Thirlby, MD, of Traverse City, who served as host for the conference as recently as the late 1960's.

MAFP Scientific Session Aug. 7-10 at Sugar Loaf

A diversified scientific program is planned Sunday-Wednesday, Aug. 7-10, at Sugar Loaf Village in Cedar by the Michigan Academy of Family Physicians.

Thirty medical and social presentations are scheduled Monday morning and afternoon, Tuesday morning and Wednesday morning. Afternoons are free Tuesday and Wednesday for recreation and family activities at the resort.

On Sunday, Aug. 7 from 7 to 9 a.m., a psychological counseling session is planned for physicians and spouses on "Living with a Doctor." An AAFP teacher-preceptor workshop in family medicine is scheduled from 1:30 to 5:30 p.m. Wednesday afternoon.

The William J. Stapleton, Jr, MD, Memorial Lecture is scheduled at 10 a.m. Monday, Aug. 8, and six independent study courses are available from 3 to 6 p.m. Monday.

Further information is available from Rita Feldkamp, MAFP executive secretary, 933 Wing St., Plymouth 48170.

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"On behalf of the FBI in Michigan . . ."

Senior Resident Agent Ted Klimaszewski of our Lansing Office has forwarded to me a copy of the Special Report of the MSMS Medicaid Liaison Committee dated April 12, 1977. On behalf of the FBI in Michigan, I commend the recommendation of the committee in its willingness to assist our agency in detecting fraud against the United States Government. It is especially encouraging to note the representative number of physicians throughout the state who have volunteered to assist our agents. The many successes enjoyed by the FBI in the past have been the direct result of aid received from concerned citizens.

Your continued assistance in these matters is greatly appreciated.

Very truly yours,
Robert E. Kent
Special Agent in Charge, FBI, Detroit

" . . . an error . . . "

The April edition of *Michigan Medicine* contains an error on page 176, where it lists me as the director of medical education at *Hurley Hospital,* Flint. I do require that a correction be made, since I am the director of medical education at *St. Joseph Hospital,* Flint.

I do want to compliment you on the improvements in *Michigan Medicine* for now it is a lively, stimulating, as well as an informative journal. Keep up the good work.

Sincerely,

Lewis E. Simoni, M.D.
Director of Medical Education
St. Joseph Hospital, Flint

" . . . issues related to mandatory CME."

I read with interest the article by William Rush, MD, in the March, 1977 *Michigan Medicine.* The results of that small survey are both encouraging and discouraging. It is encouraging to note increases in educational activities and educational aids. It is also encouraging that the medical audit is being used as one need assessment technique.

The most distressing result comes from the data reporting the effects of the new law. Why are the effects not related to health care delivery? Where is the effect on physician behavior? Patient care? I am certain that the effects reported are not the ones intended by the law. Is it too soon to see effects on patient care? Do we really expect that making education mandatory will change patient care? Can we document changes in patient care resulting from continuing education?

(See related article on page 306)

Doctor Rush states the real action arena: "Existing methods must be modified and new means of measuring competency must be developed as a means to reach our common goal — optimal health care for our nation." This is where we need to be spending our energies. I venture a guess that if we would have spent the manhours logged in seeking accreditation on the problem of making more precise the identification and measurement problems related to physician competence that major gains would have been made in moving toward optimal health care for Michigan citizens.

Is it too presumptuous to think that a legislator could read this article and take serious issue with the reported effects of the new law? Is it timely for *Michigan Medicine* to take a leadership role in the area to help focus on the critical problems and call attention to the transitional nature of *mandatory* continuing education?

Cordially,

Floyd C. Pennington, PhD, Director
Office of Continuing Education
Department of Postgraduate Medicine
and Health Professions Education
U-M Medical Center

"I would like to suggest an additional (tip) . . ."

I would like to commend *Michigan Medicine* for publishing "Tips for drug control by Michigan Physicians" in the April issue.

In addition to the five tips in that news article, I would like to suggest an additional one:

- Prescribe only one medication per prescription blank.

Such a customary prescribing practice immediately alerts pharmacists that a significant alteration of the physician's prescription has occurred if they receive a prescription on which there is more than a single medication, particularly if it is a "controlled substance."

Pharmacists are witnessing an increasing degree of alterations and adaptations to the legitimate prescribing system by persons attempting to obtain drugs for illegitimate purposes.

Following the "tips" published in *Michigan Medicine*, plus the suggestion above, will add an important safety dimension in the physician-pharmacist relationship in providing the valid therapeutic needs for the bona fide patient.

Sincerely,

Louis M. Sesti, R.Ph.
Executive Director
Michigan Pharmaceutical Association

We get letters

Here's a quote from one we recently received: "How can you suggest that people avoid using the Emergency Room when they have no place else to go? Have you tried to get an appointment with a doctor lately?"...There is more, of course, but we think that's enough to make the point. People do go to emergency rooms for non-emergencies because they have difficulty in seeing a doctor.

Why don't you take another look at your office hours and see if maybe, just maybe, you might want to extend them a little or change them somehow to make it a little easier for people to get in to see you rather than to have to go to a hospital emergency room.

After all, all of us have a stake in this whole matter of health care costs. You can exert a positive influence on cost reduction efforts by not sending people with non-emergency symptoms to hospital emergency rooms.

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Medical Practice Board needs active MSMS support

By Frederick W. VanDuyne, MD, President
Michigan Medical Practice Board

The status of Michigan MDs who did not comply with the 1976 requirements for CME is described in the following excerpts of the report delivered to the MSMS House of Delegates meeting May 13-15 in Troy. Other current issues of the Board also are described.

With one year's experience of implementing the continuing medical education provisions, rules and regulations it is obvious that some improvements and changes are necessary. However, in spite of numerous problems and inadequate assistance, the staff members of the Medical Practice Board have done a tremendous job in carrying out this job.

There are only approximately 300 physicians practicing in the State of Michigan who have not fulfilled their continuing medical education requirements. Of those physicians applying for a waiver, 20 have been denied at the present time. There are somewhere in the area of 1,200 to 1,400 physicians who do not reside in Michigan who have not fulfilled their continuing medical education requirements and it is too soon to indicate what their actual status will be.

The problem of the retired or the semi-retired physician remains a difficult one for us all because the law does not allow any latitude in terms of issuing a "limited license" to a retired or semi-retired physician. The Board's position now is the same as it was last year in that if a physician is rendering patient care, to even a small number of patients, his training and education should be kept up to date. The Board, however, is anxious to try and solve this problem.

As I mentioned earlier, the question of working out a "grace period" and a consistent technique of notifying physicians who failed to comply, and giving them a reasonable time to comply before revocation, has yet to be worked out and hopefully will be by the end of 1977.

The excellent job the Michigan State Medical Society has done in terms of certifying institutions for Category I credit has, in the Board's opinion, made Category I credit available to all physicians in our State and with a minimum of effort and expense.

Since Doctor Van Duyne made this report to the MSMS House of Delegates, the State Department of Licensing and Regulations has determined less than 100 medical doctors will be ineligible for relicensure because of their failure to meet CME requirements. According to William Ballenger, DLR director, "Michigan's new CME law did not adversely affect the number of doctors serving the public."

Complaint Investigations

In the area of investigation of complaints there has been some real improvement in that the Medical Sciences Unit of the Department of Licensing and Regulation has been implemented. Although this unit originally was to have 25 members and now only has 10, it nevertheless is beginning to unravel some of the tremendous backlog of complaints and investigations that have piled up over the past two years. It should be noted, however, that the number of investigators is still woefully inadequate.

During 1976 there were 140 complaints received in the Board office. Of these, 86 were deemed worthy of investigation. Of these, 41 cases were closed after the investigation revealed that there was not adequate information to proceed as there was no clear violation of the Medical Practice Act. The Board issued six limited licenses, suspended four licenses, placed three physicians on probation, issued one letter of reprimand, had one physician voluntarily surrender his license, and had four revocations during the year of 1976.

Implementing the portion of the law that requires us to review malpractice cases where the judgment has gone against the physician remains a great problem. Approximately 700 such cases have come to our attention in the year and one-half since the law was enacted. Many hours have been spent trying to classify these cases in order to decide which ones should be investigated. The problem is further complicated by the fact that the information and details received from the courts and from the Insurance Bureau are so sketchy and inadequate that it is virtually impossible for a Board member to examine a file, even in great detail, and make a determination if the malpractice case was also a violation of the Medical Practice Act. A solution to this problem is uncertain at the present time.

Medicaid Fraud

In the area of Medicaid fraud, there has been also great frustration for the Board in assuming its legitimate and necessary role. During the early part of the year we were virtually unable to get the names of the physicians the Department of Social Service had suspected or accused of fraud and we did literally "have to rely on the newspapers" to get some indication of the physicians involved.

When details of that communication were worked out it also then became evident that the Department of Social Service would not make available to us data that indicated the individual consumer involved in a particular fraud case.

Therefore, our hands are tied in that there is no way that we can move to suspend or revoke a physician's license in a Medicaid fraud case unless we have the names of the clients who would then be willing to come forward as witnesses and testify as to when the fraud took place, what date, under what circumstances.

It needs to be pointed out again and again, to the Legislature, to the press, to the citizenry at-large and to the profession that the Medical Practice Board cannot remove or "lift" a doctor's license without adequate testimony, due process, and detailed investigations that identify and prove a doctor's action.

There have been some problems arising in the implementation of the amendments that require hospitals, medical societies, specialty societies, etc., to report disciplinary actions to the Board. Although the Board has sent letters to all of these institutions, it is obvious that many are not complying with these requests. It is my feeling that the Michigan State Medical Society, particularly through the Judicial Commission, could aid in paving the way for a smooth and rational transmission of this kind of information. Some equitable and fair method to do so is going to have to be worked out and for the hospital or society to abolish "disciplinary action" in order to evade the law is merely asking for further government intrusion and subpoena of records.

As I indicated in my report a year earlier, I believe the medical profession has the responsibility to take the necessary disciplinary action on a local level and to transmit that information to the licensing boards so that if the physician's behavior is abhorrent enough a suspension or revocation can be contemplated.

The burden, the time, the difficult decisions that Medical Practice Board faces now and in the future, are excessive. It is imperative that the MSMS Liaison Committee with the Medical Practice Board become one of the most active committees in our organization. The attempt at changes in licensing regulation and recertification will have a profound and intimate effect on all physicians in the next few years. The greater input, liaison and understanding that can be developed through this committee, the better.

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Activities of the Michigan Medical Practice Board April and May, 1977

By Sherry Wellman
MSMS staff assistant for Government Agency Liaison

1. The Board noted with regret the resignation of Osbie J. Herald, MD, of Muskegon, due to health reasons.

2. Donald N. Sweeny, Jr., MD, Detroit Board member, has been appointed to the newly formed Committee on Physicians' Assistants. The Committee is composed of four physicians' assistants, one MD and one DO from their respective boards, and one public member. The committee is in the process of certifying over 75 PAs who have applied. Application forms are available from: Committee on Physicians' Assistants, Department of Licensing and Regulation, P.O. Box 30018, 1033 S. Washington, Lansing 48909.

3. The Medical Practice Board is mailing to every physician a form for "Application to Supervise a Physicians' Assistant." Copies are also available from MSMS.

4. The Board has requested an opinion from the attorney general whether midwifery is the practice of medicine.

5. Substitute Senate Bill 15 is opposed by the Board. The bill calls for a mandatory one-year revocation of the license of a physician convicted of Medicaid fraud. The Board believes any physician convicted of fraud should be disciplined, but would rather have the option of other sanctions, such as utilizing the physician's services in a controlled setting.

6. Physicians who received a waiver of the CME requirements may be investigated under the sick doctor provisions, if the waiver was based on physical or mental impairment. Apparently, some of the documentation by the doctors' personal physicians, led the Board to believe the conditions were serious enough to affect the ability to practice medicine.

7. The CME reporting form for 1978 has been approved and will be on cards suitable for computer processing. The forms will not be sent out until the 1978 re-registration process begins, about November, 1977. However, if a physician makes a special request to the Board, a copy will be sent.

8. The Board is nearing completion on proposed rules and regulations on amphetamines. During the past two years, the Board has drawn on the expertise of practicing physicians, speciality societies, MSMS, HEW and the AMA. The proposed rules will be published by MSMS when finalized.

9. The Department of Licensing and Regulation reported that as of April 28, 167 resident Michigan physicians have still failed to submit CME credits. This number does not include physicians who received a waiver or who did not re-register. The Board has offered each of the 167 physicians the opportunity for a hearing before suspending the license.

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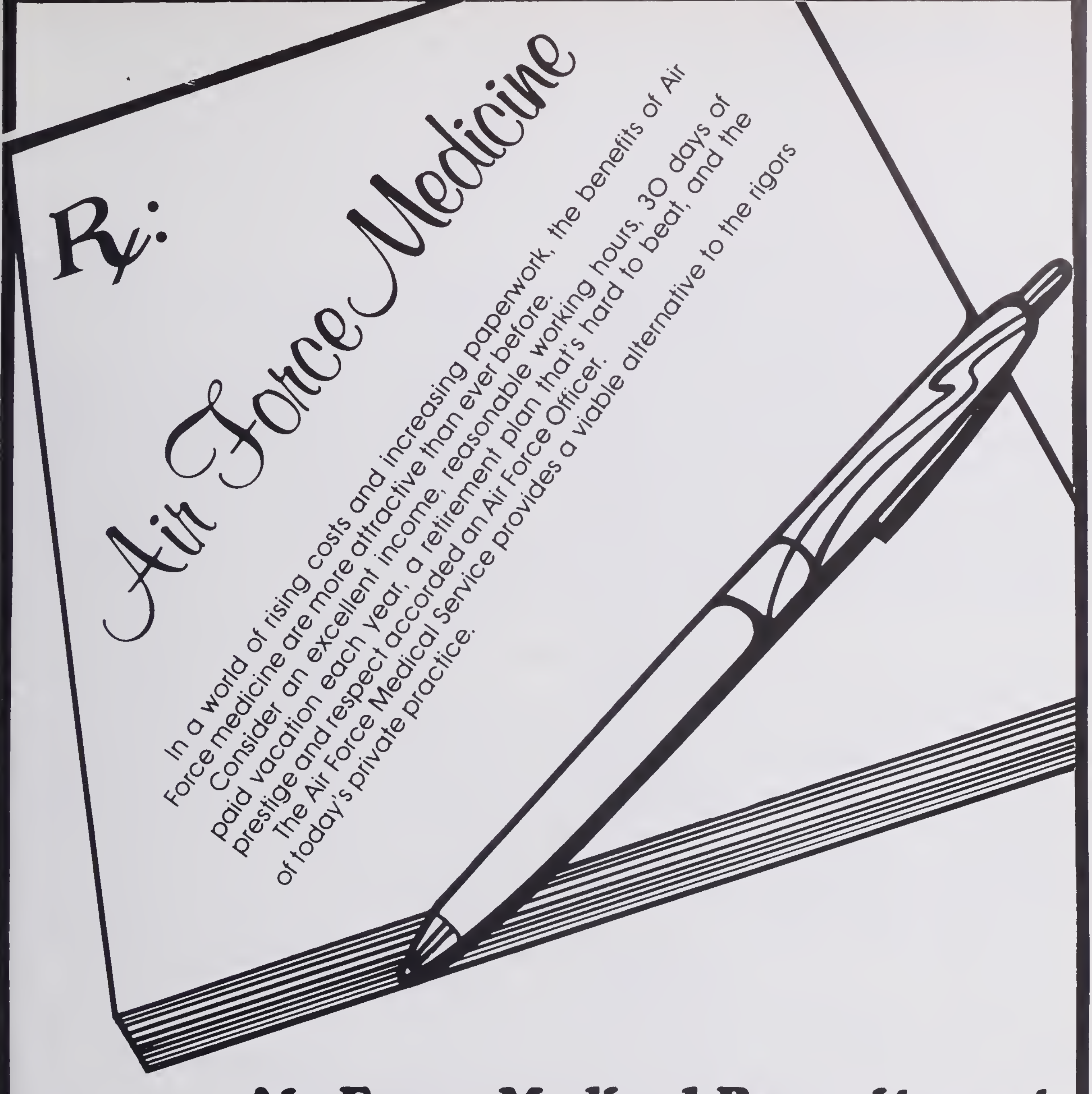

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In Memoriam

Howard O. Gray, MD
Detroit

Howard O. Gray, MD, died April 3 at the age of 58. Doctor Gray, of Detroit, was the first black physician in Michigan to be certified by the American Board of Urology. He was former chief of staff at Southwest Detroit Hospital and was on the staffs of Harper-Grace, Hutzel and Detroit Memorial hospitals. Doctor Gray was a graduate of Wayne State University School of Medicine.

Thaddeus S. Huminski, MD
Grosse Pointe Park

Thaddeus S. Huminski, MD, Grosse Pointe Park, died April 11 at the age of 62. Doctor Huminski was a general practitioner as well as an obstetrician and a pediatrician. A graduate of Wayne State University School of Medicine, he was affiliated with Holy Cross Hospital in Detroit. He served in the military as a flight surgeon for 3½ years.

Eugene A. Osius, MD
Detroit

Eugene A. Osius, MD, of Detroit, senior surgeon at Harper Hospital, died April 25 at the age of 79. A full-time surgical specialist in vascular diseases, Doctor Osius received his medical degree from the University of Michigan. He had been on the Harper staff since 1928. Doctor Osius was clinical professor of surgery, general surgery and peripheral vascular disease at Wayne State University School of Medicine. He was a member of numerous medical organizations which include the American Board of Surgery, Western Surgical Association, International Cardiovascular Society and the Cardiovascular Club. Doctor Osius had been a MSMS delegate intermittently from 1941-1961.

Charles J. Pelletier, MD
Royal Oak

Charles J. Pelletier, MD, 66, of Royal Oak died April 24. A graduate of the Wayne State University School of Medicine, Doctor Pelletier was founder of the Marie Goretti Clinic in Royal Oak. He was chief of general medicine at Crittendon Hospital in Rochester, and also had been affiliated with Ardmore Hospital in Ferndale. During World War II he served as a battalion surgeon.

Rufus Reitzel, MD
Mt. Clemens

Mt. Clemens surgeon Rufus Reitzel, MD, died April 23 at the age of 76. Doctor Reitzel served his internship and a two-year residency at Henry Ford Hospital. He opened a private practice in Mt. Clemens in 1931 and practiced for 42 years. He was a captain in the medical corps during World War II.

James L. Tyson, MD
Big Rapids

Longtime Big Rapids surgeon James L. Tyson, MD, died April 13 at the age of 55. Doctor Tyson was a chief of staff of Community Hospital and was on the staff of Mecosta County General Hospital until his death. A graduate of the University of Chicago Medical School, he was director of the Mecosta County Cancer Society for many years. He served in the Navy during World War II.

Maurice H. Seevers, MD
Ann Arbor

Maurice H. Seevers, MD, internationally known drug expert for more than 30 years and professor emeritus of pharmacology at the University of Michigan, died April 20 at the age of 75. A graduate of the Washburn University and the University of Chicago where he received both PhD and MD degrees, Doctor Seevers served on the University of Wisconsin Medical School faculty for 12 years before coming to the U-M in 1942 as fourth chairman of pharmacology. He also served as associate dean of the U-M Medical School for several years. After his retirement as pharmacology chairman, he traveled worldwide investigating drug abuse for the United Nation's World Health Organization (WHO). Doctor Seevers' many honors include the first Nathan B. Eddy Memorial Award given in 1974 by the National Research Council of the National Academy of Sciences for excellence in drug dependence research.

Edward J. Tallant, MD
Birmingham

MSMS Councilor and Wayne County Medical Society president-elect Edward J. Tallant, MD, age 63, died April 6. A graduate of the Jefferson Medical College and the University of Philadelphia, Doctor Tallant was a staff physician and former chief of medicine at Detroit's Mt. Carmel Hospital. He taught at the Wayne State University School of Medicine, and was a past board vice-president of the Federation of Physicians as well as past president of the Detroit Gastroenterology Society. Doctor Tallant was also former associate editor of the Detroit Medical News, and chairman of the MSMS Publication Committee. He was a councilor for seven years.

Classified

NEEDED: Internists for the Traverse City, Oak Park, and Lansing offices of the Disability Determination Program under Social Security. Salary currently in high $30,000's plus 22% fringe benefits, including life, accident, longterm disability, and hospital insurance. Deferred compensation. Pension benefit after 10 years. No malpractice insurance required. 40 hour work week. No weekends or nights. 50 hours continuing medical education benefit. Job involves review of medical records, training and teaching, as well as some public relations. An equal opportunity employer. All inquiries treated confidentially. For further details, please write: Disability Determination Program, Box 30011, Lansing, Michigan 48909, OR call collect: David P. Gage, M.D., Chief Medical Consultant, (517) 373-7789.

YPSILANTI STATE HOSPITAL, an agency of the Michigan Department of Mental Health, has immediate openings for (2) physicians in the Division of Clinical and Hospital Services. Michigan licensure required. Salary from $35,558 to $37,938 depending upon qualifications. The Ypsilanti State Hospital is located near the University of Michigan and is an innovative facility for the treatment of the mentally ill. All Michigan Department of Civil Service benefits and forty (40) hour normal work week. An equal opportunity employer. Respond to V. A. Stehman, MD, Chief, Clinical Affairs, Ypsilanti State Hospital, 3501 Willis Road, Ypsilanti, Michigan 48197.

PEDIATRICIAN Available immediately. (Board eligible) NY FLEX. Two years postgraduate training Karachi Univ. (1250 beds), Pakistan. University trained USA (State University Kings-County Hospital and Lenox-Hill-New York Hospital — Cornell Medical Center). Desires solo, associate, group, hospital. Salary guarantee negotiable. Telephone (914) 631-0194 (6 pm - 8:30 am) Fazal Ahmad, MD, 100 College Avenue, North Tarrytown, NY 10591.

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— Contact Jeff Reinert, Administrator, Rawlings County Hospital, Atwood, Kansas 67730.

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PUBLIC HEALTH PHYSICIAN — To provide public health leadership, direction, and participation in public health service program in a local health department.

Requirements: Licensed to practice medicine or osteopathic medicine and surgery in Michigan. Masters degree in Public Health.

Salary commensurate with experience — $31,194-$37,938. Appointment through Michigan State Civil Service. Those interested may send applications and Social Security Number and copy of license to: Public Health Physician, P.O. Box 30001, Lansing, MI 48909.

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POSITIONS AVAILABLE. For the Lansing office, two Internists and one Psychiatrist — For Traverse City, a part time or full time Internist — and for Oak Park, one Internist and possibly one Psychiatrist, — These physicians to be with the Disability Determination Program under Social Security Administration. Salary currently in high thirty thousands, plus 22% fringe benefits, including life, accident, long term disability and hospital and major medical coverage. An outstanding benefit is deferred compensation. Pension benefit after 10 years' service. Liability insurance not necessary. 40 hour work week. No weekends or nights. 50 hours allowed for obtaining necessary CME credits. Vacation leave and sick leave is given. Position entails review of medical records, training and teaching of disability examiners, as well as some public relations. An equal opportunity employer. All enquiries treated confidentially. For further details, please write: Disability Determination Program, Box 30011, Lansing, Michigan 48909, OR call collect: Harry D. Nesmith, M.D., Chief Review Physician, (517) 373-7789.

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ATTRACTIVE OFFICE SPACES now available for rent in the Muskegon Mall area. Located in the Medical Arts Plaza, 315 West Clay Avenue, Muskegon, Michigan. Reasonable rates with many modern conveniences. For further information please contact Mrs. Westerman, (616) 726-3641 or after 5:00 p.m. (616) 725-7120.

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G.P.F.P. needed to associate with three G.P.'s in city with three general hospitals. Excellent fringe benefits, liberal vacations and coverage. Contact A. G. McCuaig, M.D., 719 Capital Avenue, S.W., Battle Creek, MI. Telephone 616/965-2277.

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WANTED: Staff physician, Michigan license required, for 350-bed fully accredited hospital for the care of rehabilitation, tuberculosis, psychiatric and chronic disease patients. 40 hours week. Excellent salary and fringe benefits. Contact: Personnel Director, Saginaw Community Hospital, 3340 Hospital Road, Saginaw, Michigan 48605.

PEDIATRICIAN — BOARD CERTIFIED: Solo practitioner desires associate for practice in Southeastern Michigan near Downriver Area. Terms negotiable. Send replies to MSMS, 120 W. Saginaw, Box 3, East Lansing, MI 48823.

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FDA considers Laetrile unrecognized 'new drug'

Questions about the efforts of some to promote the use of Laetrile in Michigan and other states lead to questions about the FDA position on Laetrile.

The FDA position, which has been constant for some time, is as follows:

- FDA has considered Laetrile a "new drug" within the meaning of Section 201(p) of the Federal Food, Drug, and Cosmetic Act, in that it is not generally recognized among experts qualified by scientific training and experience to evaluate the safety and effectiveness of drugs as safe and effective for use in the cure, mitigation, treatment or prevention of cancer in man.
- Federal law prohibits the interstate distribution of a "new drug" unless FDA has approved a New Drug Application (NDA) submitted by the sponsor and containing full reports of clinical investigations establishing the safety and effectiveness of such a drug.
- While Laetrile has been marketed and promoted as a vitamin (Bee 17 or B-17), FDA has no basis for accepting the claim that Laetrile is a vitamin and not a drug. It is of no value as a factor in human nutrition.

CLASSIFIED/*Continued*

PHYSICIANS ASSISTANT — Graduates from Western Michigan University August 1977 with B.S. degree in medicine, AMA approved. Seeks small group or solo practitioner that could utilize a PA. B.S. University of Wisconsin, four years experienced corpsman in U.S.N. Write or call Donald Faulkner, 1605 W. North Street, Kalamazoo, Mi, 49007, 616/349-2705.

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PEDIATRICS, Educational Program Coordinator. Applications are being accepted for this full time staff position with the Southwestern Michigan Area Health Education Center. To be considered, an individual must be a fully trained pediatrician and certified (or imminently so) by the American Board of Pediatrics. Duties and responsibilities will encompass many areas of activity including undergraduate, graduate, and continuing medical education. A complete job description is available upon request. Compensation will include a generous stipend and fringe benefits package as well as a regular appointment to the faculty of the College of Human Medicine of Michigan State University. For details contact: Robert M. Nicholson, MD, Executive Director, Southwestern Michigan Area, Health Education Center, Suite #364, 252 East Lovell, Kalamazoo, MI 49006, (616) 383-7896.

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Potpourri

By Herbert A. Auer, Executive Editor

Did you know that — there is one employe in the Federal Department of Agriculture for every 34 farmers?

* * *

At the University of South Florida more than 300 professors each carry $250,000 of professional liability insurance. Disputes, it is reported, are most common over grades. Across the nation there is a new trend of suits by college students against their professors.

* * *

Add to the list of unusual hobbies . . . Al Turcke, MD, president of the Genesee County Medical Society, has collected more than 100 hippopotamuses — or is it hippopotami — made from glass, jade, brass, pewter, silver, wood, plastic, etc. You see some in his medical office, but there are more in the Turcke home in Flushing.

* * *

Government doesn't create jobs; jobs are created by investment. To make that point, Doctor Richard L. Lesher, president of the Chamber of Commerce of the United States, uses this example:

"If you want to open a store, you need a lot of start-up money, money for such things as rent, stock, advertising and pay for your staff until the cash starts coming in. The same principle applies to heavy industry, only more so. Big industrial processes require big, expensive machines. On the average, it takes $40,000 today to create one blue-collar job."

* * *

Because they are afraid their shoes will come off, basketball players and trackmen tie their shoe laces too tight, William G. Clancy, Jr., MD, the Wisconsin University team physician, told the MSMS Conference on Medical Aspects of Organized Athletics. The tight shoe laces can lead to tendonitis and other problems, he reported.

* * *

The failure of the medical profession and the scientific community to communicate effectively to the people "leads the world to look at the practice of medicine and of research as hopelessly confused and in need of new laws and better business management," writes Irvine H. Page, MD, editor of *Modern Medicine*. He says the problem of town and gown is bad enough, but "there is almost arrogant isolation of the components of medicine and science."

* * *

Lawrence J. Peter in the *Peter Principle,* writes "The obscure we see eventually, the completely apparent takes longer." About his book, he says, "There is less to this than meets the eye."

* * *

The freshmen now at Michigan State are generally more conservative than the student of 1971, according to a survey conducted by Arvo Juola of 1,000 students. But students now want fewer regulations and requirements.

* * *

The next time you feel good or bad, you can connect it to the weather. Biometeorologists report that research shows we think best on cool, dry days . . . we have most auto accidents when the barometer is falling . . . more people flunk civil service exams in July and August than during the cooler months. And you may already know that certain medicines like morphine and digitalis are more potent during storms.

* * *

Tenley Albright, MD, Boston surgeon who was the 1956 Olympic Women's Figure Skating Champion, promotes physical fitness and such sports as tennis, swimming and jogging. But she also points out that "10 minutes of climbing stairs can be very valuable."

* * *

One of every four American children under 18 lives in poverty — a total of 17 million children, reports the Coalition for Children in Youth, Washington, D.C. The Coalition observes that while the child population in the USA is decreasing with the falling birth rate, a larger percentage of children live in poverty today than in 1970.

* * *

Michigan Medicine Contents

***Michigan Medicine*, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about contemporary issues and actions of the Michigan State Medical Society, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.**

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Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

In the next issue . . .

Progress report on key medical legislation

President's Page

Vernon V. Bass, MD
MSMS President

How the AMA works

I have just returned from the AMA Annual Convention June 18-22 in San Francisco. I witnessed the inauguration of new AMA President John Budd, MD, Ohio, and joined with delegates from all 50 states to help elect Thomas Nesbitt, MD, as AMA president-elect.

I stood on the great stage at the Fairmont Hotel, representing Michigan, and it thrilled me to be a part of that democratic assemblage.

It is very democratic, you know. The AMA is a federation of 55 constituent societies, most of them state medical associations. The constituents are composed of component societies which number 1,931. Each state has a delegate for every 1,000 active AMA members in residence. Michigan has the sixth largest delegation, with eight delegates and eight alternates. Robert E. Rice, MD, Greenville, leads our state's delegation.

It is the 256 AMA delegates who elect the members of the AMA board of trustees, and who elect AMA officers and council members. Specialty sections, interns and residents and medical students also have delegates. The Army, Navy, Air Force, VA and PHS are represented.

Any physician who wants to initiate national AMA policy has a chance. The procedure is to convince the state delegation to sponsor a resolution, which goes to AMA reference committees during the semiannual conventions, and then, if successful, to the full AMA House for voting.

All this procedure, of course, has set the pattern for state societies, including our own MSMS House of Delegates.

AMA policy is carried out by the AMA Board of Trustees, comprised of the president, president-elect, immediate past president and 12 trustees elected by the House.

Eight AMA Councils investigate, develop, and evaluate new scientific information and methods to improve the quality of medical education, medical care and health care delivery to the public.

The AMA is basically a scientific and educational organization. The AMA spends 35% of its annual multi-million dollar budget for scientific service to physicians; 18% to promote and improve the effective delivery of care; 11% for direct service to the public; 11% to assure and continue to improve the quality of medical care; 9% to strengthen organized medicine; 8% to represent the medical profession, and 8% for internal support for AMA policy and management activities.

When **impotence** due to androgenic deficiency is driving them apart

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Methyltestosterone U.S.P. – 5, 10, 25 mg.

New Double-Blind Study ANDROID-25 *vs.* Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg. Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.**: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974 **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Ernest P. Griffin, Jr., MD

(The following declarations were made by MSMS Council Chairman Ernest P. Griffin, Jr., MD, Flint, in his report before the MSMS House of Delegates' meeting May 13-15 in Troy.)

You Must Remember:

- Only physicians can practice medicine.
- Only physicians can know and appreciate the disastrous consequences of edicts delivered by persons who have no conception of what medical practice is all about.
- Only doctors and a small segment of the public realize the amount of a physician's time that is spent in furnishing unnecessary medical care to a public that is reluctant to accept any responsibility for their own health.
- Only doctors comprehend that federalization of medical care in this country will result in three things:
  a) the destroying of the finest medical system in the world today
  b) an enormous increase in costs due to the unsated public demands for so-called medical care, and
  c) the untold number of bureaucrats that it will require to manage the system.

Michigan well represented at AMA meeting

Approximately 40 Michigan physicians participated in the scientific program at the just-completed AMA Annual Convention in San Francisco.

Serving as course directors were Paul Gikas, MD, Ann Arbor, urologic pathology, and Franklin V. Wade, MD, Flint, diagnosis and treatment of fractures of the lower extremities.

Harold F. Falls, MD, Ann Arbor, gave the chairman's address for the Section on Ophthalmology, while Lee B. Stevenson, MD, Farmington, served as ob/gyn section representative to the scientific exhibits.

Making presentations were Michael C. Tomlanovich, MD, Bloomfield Hills and Judith E. Tintinalli, MD, Detroit, "Practical Exercises in Emergency Care;" Norman D. Nigro, MD, Detroit, and George T. Bradley, MD, Southfield, "Colorectal Neoplastic Disease"; Thomas F. Downham, II, MD, Detroit, "Systematic Toxic Reactions to Procaine Penicillin G"; Charles E. Lucas, MD, Detroit, "Cause and Prevention of Stress Ulcers," and "Surgical Management of Gastroduodenal Bleeding"; Michael A. Wainstock, MD, Detroit, "Ultrasonic Guided ϒ Probe for Intraocular Melanoma Detection"; Harold Weiss, MD, William Annesley, MD, Jerry Shields, MD, and Terrance Tomer, MD, Detroit, "The Natural History of Serpiginous Choroidopathy"; and Robert Fekety, MD, Ann Arbor, "The Treatment of Anaerobic and Mixed Aerobic/Anaerobic Infections."

Speakers for the 19th National Conference on the Medical Aspects of Sports June 18 included Morton S. Cox, Jr., MD, and Gary S. Sandall, MD, both of Ann Arbor.

Taking part in section exhibits were Remigio Garcia, MD, E. L. Quinn, MD, T. Madhaven, MD, D. Magilligan, MD, and K. H. Burch, MD, Detroit, cardiovascular diseases; Richard L. Hatton, MD, Okemos, family practice; Irving Feller, MD, Ann Arbor, and James R. Lloyd, MD, Detroit, general surgery; J. B. Butterfield, MD, Detroit, neurological surgery; Alvin H. Crawford, MD, and G. Dean MacEwen, MD, Detroit, orthopedic surgery; John W. Rebuck, MD, and Joseph P. Abraham, MD, Detroit, pathology; John R. Thornbury, MD, Terry M. Silver, MD, and Ananias C. Diokno, MD, Ann Arbor, Y. M. Ting, MD, John E. Curran, MD, and Nabil F. Maklad, MD, Westland, radiology; Thomas J. Mertz, MD, and Joseph C. Cerny, MD, Detroit, urology, and Vergil N. Slee, MD, Ann Arbor, allied medicine.

Just what the doctor ordered . . .
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89
63
61
7
56
7

Quarterback Eddie Smith (7), the Big Ten's leading passer and total offense leader last year.

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Season tickets assure you of the same good seats for each game, so send in your application today!

Kirk Gibson, the Big Ten's leading pass receiver, scores against Wyoming.

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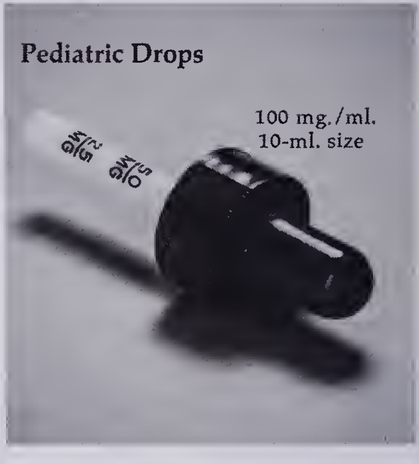

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Special article

Younger physicians putting more faith in organized medicine

By Judith Marr
Managing Editor

There is a changing attitude among students and residents. They want to become involved.

"They now believe that organized medicine has something to contribute," says Thomas E. Stone, MD, Muskegon, 41, who this spring served his fourth term as a delegate to the MSMS House of Delegates.

"There is still some suspicion on the part of young physicians that MSMS is a powerless, ineffective organization," he says. "But this feeling is lessening."

Doctor Stone; Willard S. Stawski, MD, Grand Rapids; and Malcolm D. Steider, MD, Coldwater, were gathered in the MSMS news room during the 1977 MSMS House of Delegates meeting. They were discussing the impact of the meeting and the general course of MSMS activities.

"It is our obligation to try to get house officers involved in the issues of practicing medicine," said Doctor Stawski. "I'm 37 and just now starting to be knowledgeable about third party carriers. We shouldn't wait so long. We should make it easy for the young doctors to become involved."

Doctor Stawski is serving his first term as a delegate after one year as an alternate. He feels strongly interested in house officers, he explained, as there are over 250 physicians-in-training in his home area.

"We (organized medicine) have no input from these people and they are terribly important," he said. "It's wrong not to at least ask them their opinion."

The three young doctors were in favor of the 1977 resolution proposed for the fourth consecutive year making membership in MSMS mandatory for state licensure. They said they believe students and house officers would not be opposed, with their new interest in organized medicine.

"People realize the futility of simply bitching," commented Doctor Stawski. "They don't feel the establishment is all that bad. Without it, you cry alone."

Doctor Steider, who is 38, also said he is encouraged with the younger ages of the new Michigan delegates to the AMA. But Doctor Stawski was not in favor of regular meetings around the state for under-40 physicians.

"They would lack appeal," he said.

Rather, he said, it takes a liaison person with a real interest in young doctors to bring them into an organization and inspire with zeal for the organization's causes.

He cited the example of C. Harold Ross, MD, of the University of Michigan, who impressed on medical students the importance of medical economics and the practicalities of

Thomas Stone, MD:

" . . . organized medicine has something to contribute . . . "

relationships with third party carriers.

"You have to have someone like this, who will extend the plank to young physicians," he said.

The MSMS House of Delegates' meeting was very impressive, according to Doctors Stawski, Steider and Stone.

"This meeting is a fantastic manifestation of democracy in action," said Doctor Stawski. "I'm not meaning to sell apple pie and motherhood. It's true. Anyone can get up and say what he or she wants to.

"I don't know whether other conventions work this way, but physicians are such a notoriously independent group. They stand up and say what they think. I think it's exciting."

Doctor Stone observed how the delegates' discussions serve as a sort of "vocal catharsis." You can't get anyone at home to listen like here."

Willard Stawski, MD:

" . . . our obligation to try to get house officers involved in the issues . . . "

Indeed, the biggest problem of the House meeting, said Doctor Steider, is trying to carry some of the "fervor, enthusiasm, passion" back to the grass roots level.

That is in spite of the fact, said Doctor Stone, that physicians are being forced to become more informed, because of government interference in medical practice.

"They haven't sought it (information), but everyone has been hit with this stuff and they want to know what's happening. They are getting interested after the fact.

"To be unified, you have to have dedication, believe in a cause, be willing to sacrifice," theorized Doctor Stone. "I don't think we have this zeal yet. But we are coming along, though we really have a problem in the number of members who are not yet aware or interested enough."

Malcolm Steider, MD:

Biggest problem: carrying House "fervor, enthusiasm, passion," back to grass roots.

The young doctors talked about streamlining the pageantry and the House of Delegates meeting, and of discussing all points of an issue at once, rather than scattering the issue among various resolutions.

"But we have to be patient," said Doctor Stone. "We're just starting to learn the game and can't be so definitive."

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"This mantle weighs heavy, but I am ready to do my part," said Vernon V. Bass, MD, Saginaw, second from left, as he became MSMS president for 1977-78. His installment was a highlight of the 1977 MSMS House of Delegates meeting in mid-May in Troy. Doctor Bass succeeds Robert M. Leitch, MD, Battle Creek, second from right. Witnesses were James D. Fryfogle, MD, Detroit, left, MSMS speaker, and Kenneth H. Johnson, MD, Lansing, right, MSMS secretary.

Another high point in the MSMS House actions was the election of Louis E. Heideman, MD, Birmingham, left, as MSMS president-elect. Doctor Heideman is past president of the Wayne County Medical Society and is an MSMS delegate. He is congratulated by Homer Smathers, MD, Detroit, Wayne County delegate.

Doctor Bass receives the congratulations of MSMS past president Brock E. Brush, MD, Detroit, one of many well-wishers following the inauguration.

1977 MSMS House of Delegates photos

O. B. McGillicuddy, MD, Lansing, right, receives one of the first-ever MSMS Certificates of Appreciation for his services as a delegate to the AMA. Doctor McGillicuddy, also an MSMS past president, is presented the award by MSMS immediate past president Robert M. Leitch, MD, Battle Creek.

Constituent Vickers C. Hansen, MD, Manistee, met Rep. Dennis O. Cawthorne, (R-North Muskegon) when the latter spoke at the annual MDPAC Luncheon, a feature of the House of Delegates meeting. Rep. Cawthorne is minority leader of the Michigan House of Representatives.

New MSMS councilors, elected during the MSMS House meeting, are, from left, C. Jackson France, MD, Harper Woods, and Carl A. Gagliardi, MD, Lincoln Park, both from the First District; Thomas A. Berglund, MD, Portage, Fourth District; Justin L. Sleight, MD, Lansing, Second District, and Harvey M. Andre, MD, Grand Rapids, Fifth District.

Special forums on national health insurance and physicians' private investments helped inform the MSMS delegates during the 1977 House meeting. MSMS immediate past president Robert M. Leitch, MD, standing contributed to the NHI discussion.

The luncheon and awards for Michigan physicians who have served 50 years since graduating from medical school were especially heartwarming this year for Raymond E. Sculley, MD, Grand Rapids, left, and Arthur W. Rothman, MD, Mt. Clemens. They had not seen each other since graduating 50 years ago in the same Wayne State University Medical School class, and just happened to sit next to each other at the luncheon.

Doctor, tell your legislator what you think about issues!

By William Faust
Michigan Senate Majority Leader

(The following is excerpted from a talk delivered at the annual Michigan Doctors Political Action Committee luncheon May 14 during the MSMS House of Delegates meeting. Remarks of Rep. Dennis O. Cawthorne, House minority leader.)

Pragmatically, we become most interested in government when it directly affects us. A great deal of what has been going on in government recently, at the state and national level, affects you as members of the medical profession — your career, your living, your goals.

That is the most obvious and the best reason why you should become involved in the political process. Focusing on Michigan alone, the medical malpractice insurance dilemma, the Single Business Tax and the new law requiring MDs to have 50 hours annually of continuing medical education have had a tremendous impact, financial and otherwise, on the physicians in this state.

And there are other issues that directly affect you. All of you are all too aware of the PBB tragedy. The massive revision of the state's public health code that almost made it through the legislature last year has been reintroduced and will be a priority item this year.

Several other bills pertaining to health care problems, regulations and facilities have been introduced in these first few months of the 79th session of the legislature. There are bills to legalize Laetrile and to provide heroin to addicts on a prescription basis. On the national level, the President has proposed cost controls for most of the hospitals in the country.

Sen. William Faust (D-Westland), MDPAC luncheon speaker and Senate majority leader, left, drew much attention when he advocated more physician-involvement for political effectiveness. Among those asking for elaborations were, from left, Sue K. Willison, Midland; Louis R. Zako, MD, Dearborn Heights, MSMS vice speaker, and Charles H. Willison, MD, Midland.

Quite clearly, you are directly affected by this type of legislation. What better motivation can there be for getting individually involved and helping to shape legislation? And I am not overlooking the fact that we in the legislature can benefit from your participation. You, after all, are the experts in the field of health care and we need your expertise and experience. You are members of the highest ranking profession in the world; as individuals, you have completed the highest academic standards of any profession in this nation.

As all the issues that confront society and its elected and appointed officials become more complex, we have an increasing need to tap the specialized knowledge of experts from many disciplines and professions.

How can you personally get involved? The answer to that question is important because knowing how and when to get involved is vital to influencing legislation in a meaningful way.

As with so many things, timing and technique are important.

Political action committees, such as you have in the medical profession, can be extremely effective vehicles for bringing your views on issues to the attention of government officials. The fact that a political action committee represents many members and therefore carries considerable political clout will not be lost on officials.

You can also have significant influence acting individually. Some of you . . . too few, perhaps . . . take part in the Doctor of the Week Program in Lansing. This is a good, workable program with fine results.

Then, when a bill has been introduced, let your point of view be known. The people to contact are your own legislators, the sponsors of the proposal, and the members of the committee that the bill has been referred to. How do you feel about Laetrile? How do you feel about giving heroin to addicts? Tell your legislator!

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1. For the relief of symptoms associated with cerebral vascular insufficiency.
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Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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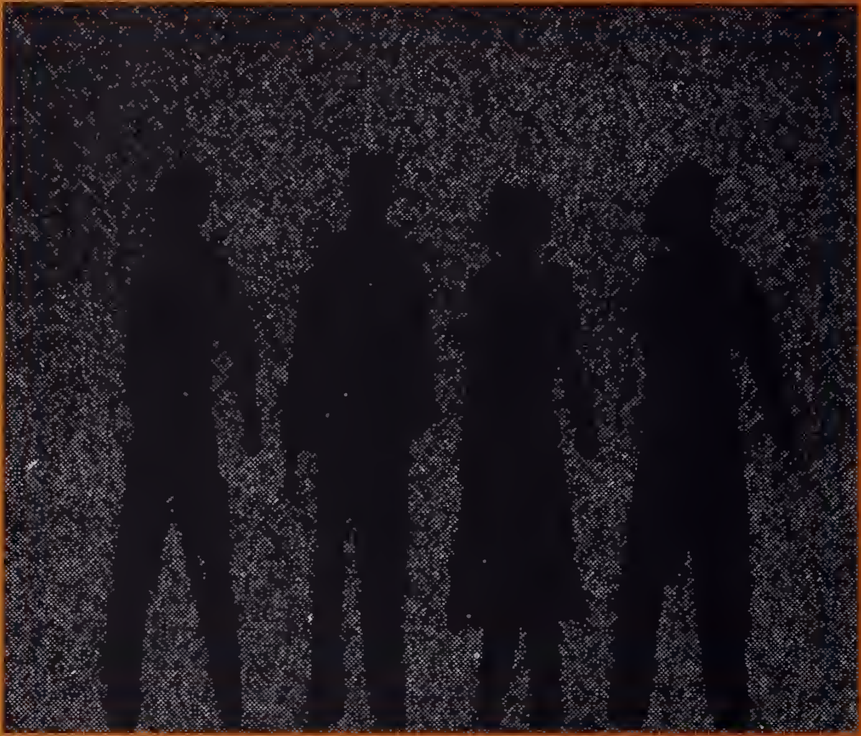
Michigan Medicine presents, on the following pages, a portfolio of demographic statistics on Michigan physicians. The figures have been compiled from a variety of state and national sources, including MSMS's own Bureau of Economics. These tables and interpretations are designed to serve as a reference guide for Michigan physicians and may be removed from the magazine for handy use.

Special section:

Michigan physicians' vital statistics



Section A

National

The information on this page comes from the AMA and gives general statistical information about the physician population of the U.S.

Table 1

Number of Physicians Compared to U.S. Population (historical trends and projections)

Year	Number of physicians*	Total U.S. population (millions)**	Physicians per 100,000 population
1925	148,665	115.8	128
1950	219,997	152.3	144
1960	260,484	180.7	144
1965	292,088	194.3	150
1970	334,028	204.9	163
1975	393,742	213.6	184
PROJECTIONS:			
1980	457,182	224.0	204
1985	530,705	236.0	225
1990	606,779	247.0	246

*Federal and non-federal physicians.

**1925 is resident U.S. population; for all other years, includes overseas-based U.S. armed forces.

Sources: (1) Louis J. Goodman, "The Supply and Availability of Physician Services," AMA Center for Health Services Research and Development, March 1977. (2) Projections from HEW, "The Supply of Health Manpower: 1970 Profile and Projections to 1990," 1974.

Over the past 50 years, the physi-
an population in the United States
ıs been growing twice as fast as the
·neral population. Production of
:w physicians has been accelerating
recent years, while the growth
te of the general population has
en slowing.

As a consequence, the physician
pulation since 1970 has been in-
easing more than four times faster
an the U.S. population as a whole.

In 1975, there were about 543 po-
ntial patients for every physician
the U.S. In 1970, the ratio was 613
rsons per physician; and the figure
1925 was 781. By 1980, according
an HEW projection, the population
r doctor ratio is expected to be re-
ced to 490.

Part of the reason for growth of
ysician manpower has been an in-
ease in the number of U.S. medical
ools, accompanied by an increase
the annual number of medical
ool graduates. The 13,561 gradu-
es in the 1975-76 school year were
arly double the number of gradu-
es in 1960-61.

Foreign-trained physicians, too,
ve contributed to the growth of
ysician manpower. These include
eign nationals and Americans who
eived their medical training out-
le the U.S. or Canada. About one of
ery five physicians in the U.S. is a
eign medical school graduate.
wever, the recently enacted Health
ofessions Assistance Act is expected
decrease somewhat the future role
foreign-trained graduates.

Measures of physician manpower
the U.S. are not precisely compar-
le with those of other countries,
cause the criteria for medical edu-
tion and licensure differ from
ıntry to country. (The U.S. stand-
ls are among the highest in the
rld.) Among leading industrial na-
ns, the U.S. has one of the highest
tios of physicians per 100,000
ulation.

Table 2

Students and Graduates in U.S. Medical and Basic Science Schools

School Year	Number of Schools	Total Enrollment	First Year Enrollment	Graduates
1935-36	77	22,564	6,605	5,183
1950-51	79	26,186	7,177	6,135
1960-61	86	30,288	8,298	6,994
1965-66	88	32,835	8,759	7,574
1970-71	103	40,487	11,348	8,974
1975-76	114	56,244	15,351	13,561
PROJECTION:				
1980-81	114*	Not available	16,063	15,512

*Based on current expansion plans of the present 114 medical schools. (Two or more additional schools are expected to be accredited by 1980.)

Source: American Medical Association, *JAMA*, "Medical Education in the United States," December 27, 1976.

Table 3

Number of Physicians per 100,000 Population in Selected Countries (1972 data)*

Country	Physicians per 100,000 population
United States	165
Canada	158
France**	141
West Germany	184
Japan	116
Netherlands	136
Sweden	147
England & Wales	131

*Latest year for which comparable data are available.
**Includes overseas departments of France.

Source: World Health Organization, World Health Statistics, 1972, Geneva, 1976.

Section B

The following information deals strictly with Michigan physicians. The first four tables and interpretations were made by the MSMS Bureau of Economics. They are followed by more details from the Michigan Medical Practice Board and then by figures generated by the Michigan Cooperative Health Information System.

As of March, 1976 .... Physicians registered to practice in Michigan 11,649

As of February 1, 1977 ... MSMS membership was 8,813

As of February 1, 1977 ... AMA membership from Michigan was 6,688

About 24% of MSMS members do not join AMA.

MSMS Bureau of Economics

The following table shows the percentage of physicians in Michigan from each specialty who are members of MSMS.

Specialty	MSMS Members*	MDs in Michigan	Percent
Allergy	74	83	89.2%
Anesthesiology	302	348	86.8
Dermatology	130	132	98.5
Family Practice	1,589	2,381	66.7
Gastroenterology	39	47	83.0
General Surgery	792	987	80.2
Internal Medicine	1,240	1,552	79.9
Neurological Surgery	66	74	89.2
Neurology	56	77	72.7
Obstetrics-Gynecology	670	769	87.1
Ophthalmology	292	329	88.8
Orthopedic Surgery	252	262	96.2
Otolaryngology	131	157	83.4
Pathology	267	357	74.8
Pediatrics	404	564	71.6
Physical Medicine	139	200	69.5
Plastic Surgery	55	56	98.2
Proctology	22	28	78.6
Psychiatry	504	802	62.8
Radiology	403	499	80.8
Thoracic Surgery	79	97	81.4
Urology	165	181	91.2
TOTAL	7,671	9,982	76.8%

*Excludes retired and associate members.

MSMS Bureau of Economics
Sept. 22, 1976

This table breaks down the MSMS membership by age.

MSMS Membership Age Analysis

Age	Number	Percent
25 - 34	476	5.9%
35 - 44	2,259	28.0
45 - 54	2,470	30.6
55 - 65	1,668	20.6
over 65	1,205	14.9
	8,078*	100.0%

*Does not represent entire membership — only those on whom historical data are available.

MSMS Bureau of Economics
March 17, 1977

Where Michigan MDs went to school

MSMS obtained computer information in January 1977 about th medical schools attended by Michigan doctors of medicine.

Of the 13,568 licensed doctors, 5,11 (or 37.7%) were graduates of the thre Michigan medical schools. Anothe 4,374 (or 32.2%) were graduates c other U.S. medical schools and 396 (o 2.9%) were from Canadian schools.

Of the 13,568 total, 3,686 (or 27.2% were graduates of foreign medic schools.

The heaviest concentrations c graduates of foreign medical schoo were Wayne with 1,894; and Oaklan with 556.

Two other counties had 100 or mor FMGS — Washtenaw with 19 Genesee with 185, and Macomb wit 160.

The counties of Genesee, Macom Monroe, Tuscola and Wayne hav more doctors who are graduates fro foreign medical schools than the have graduates from the three Mich gan schools.

No county has more FMGS tha physicians trained in the USA. Tu cola, according to the computer repor has 10 graduates of USA schools ar 10 from foreign schools.

(Continued on page 357)

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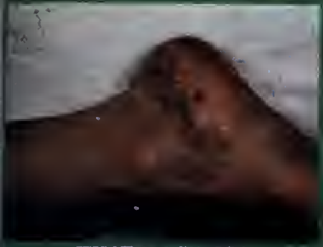
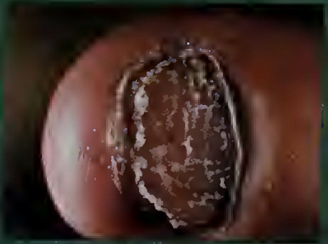


TINEA PEDIS*



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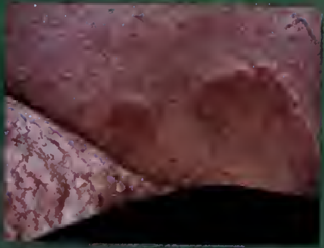
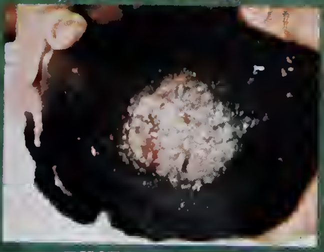


TINEA CRURIS*



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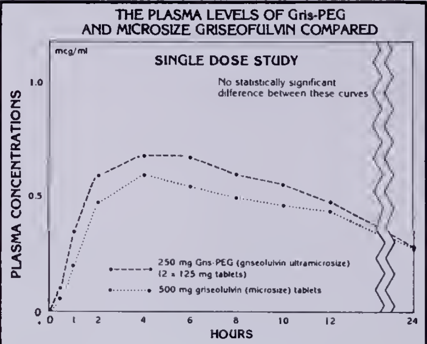
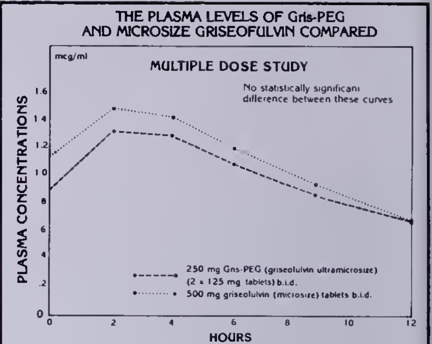

THE PLASMA LEVELS OF Gris-PEG AND MICROSIZE GRISEOFULVIN COMPARED

Based on a single dose double-blind bioavailability study conducted in 24 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels. There is no significant difference between peak plasma levels, times to peak, and areas under the curve. Gas chromatographic assay.


THE PLASMA LEVELS OF Gris-PEG AND MICROSIZE GRISEOFULVIN COMPARED

Based on a double-blind multiple dose steady state crossover bioavailability study conducted in 17 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels obtained on days 9, 11 and 13. There is no significant difference between times to peak, peak plasma levels, and areas under the curve. Gas chromatographic assay.

Gris-PEG®

(griseofulvin ultramicrosize) Tablets 125 mg

The ½ dose griseofulvin.

DESCRIPTION

Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG Tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION

Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum*, *Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsized griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy.

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS

Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis, ringworm of the nails)

when caused by one or more of the following genera of fungi:

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleini
Microsporum audouini
Microsporum canis
Microsporum gypseum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *NOT* effective in the following:

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS

This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS

Prophylactic Usage: Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5 to 2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy The safety of this drug during pregnancy has not been established.

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress. Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS

Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists; however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS

When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion, and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSAGE AND ADMINISTRATION

Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by a culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6 weeks; *tinea corporis*, 2 to 4 weeks; *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months; toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsized) USP (see ACTION Human Pharmacology).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis the following dosage schedule for children is suggested: Children weighing over 25 kilograms (approximately 50 pounds) 125 mg to 250 mg daily; children weighing 15-25 kilograms (approximately 30 to 50 pounds) 62.5 mg to 125 mg daily; children 2 years of age and younger, dosage has not been established.

Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED

Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin microsized tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin, biologically equivalent to 250 mg of microsized griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsized griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.

Dorsey
LABORATORIES
Division of Sandoz, Inc. • LINCOLN, NEBRASKA 68501

Medical Schools Attended by Michigan Physicians As of 1/21/77

County Medical Society	Michigan Medical Schools	Other U.S. Medical Schools	Canadian Medical Schools	Foreign Medical Schools	Total
Allegan	12	19		2	33
Alpena-Alcona-Presque Isle	24	14	2	3	43
Barry	14	11	1	1	27
Bay-Arenac-Iosco	48	55	2	21	126
Berrien	49	83	2	41	175
Branch	21	11		6	38
Calhoun	63	77	6	31	177
Cass	4	8		4	16
Chippewa-Mackinac	10	23		2	35
Clinton	6	4		2	12
Delta-Schoolcraft	15	18	1	4	38
Dickinson-Iron	14	25	3	2	44
Eaton	9	8		2	19
Genesee	178	175	42	185	580
Gogebic	3	9			12
Grand Traverse-Leelanau-Benzie	65	55	5	13	138
Gratiot	14	17		8	39
Hillsdale	11	5		3	19
Houghton-Baraga-Keweenaw	19	9		7	35
Huron	9	9		9	27
Ingam	176	248	19	73	516
Ionia-Montcalm	16	10		16	42
Isabella	20	16		14	50
Jackson	75	47	3	35	160
Kalamazoo	166	217	7	67	457
Kent	355	318	9	60	742
Lapeer	11	9		11	31
Lenawee	31	23	1	20	75
Livingston	16	7		14	37
Luce	8	4	1	2	15
Macomb	137	66	23	160	386
Manistee	6	6		4	16
Marquette-Alger	33	57	3	6	99
Mason	22	10		6	38
Mecosta-Osceola-Lake	14	6		2	22
Menominee	1	11			12
Midland	54	49	4	8	115
Monroe	18	25	2	26	71
Muskegon	66	79	4	16	165
Newaygo	5	8			13
North Central Counties	21	18	1	7	47
Northern Michigan	44	51	3	8	106
Oakland	658	358	39	556	1,611
Oceana	6	4		1	11
Ontonagon	5	2	1		8
Ottawa	73	34	1	5	113
Saginaw	95	84	9	72	260
St. Clair	45	27	10	23	105
St. Joseph	11	18	1	5	35
Sanilac	12	3		2	17
Shiawassee	17	18		10	45
Tuscola	8	2		10	20
Van Buren	10	19		10	39
Washtenaw	615	655	29	195	1,494
Wayne	1,659	1,222	162	1,893	4,936
Wexford-Missaukee	15	8		3	26
TOTAL	5,112	4,374	396	3,686	13,568
PERCENT OF TOTAL	37.7	32.2	2.9	27.2	100.0%

MSMS Bureau of Economics
January 21, 1977

How Michigan counties have changed MD populations

The county which has gained the most physicians in Michigan, in the past 15 years, according to the Michigan Medical Practice Board, is Oakland. Oakland had 486 doctors of medicine in 1961; 1,124 ten years later; 1,551 in 1973 and then 2,110 in 1976. That represents a gain of 334% in 15 years.

Washtenaw County had 591 doctors of medicine in 1961 and 1,216 in 1976.

In Wayne County, the number of doctors of medicine was 3,155 in 1961. The figure in 1976 was 3,333, coming up gradually from a 15-year low of 2,714 in 1972.

In Macomb, the figures jumped from 98 in 1961 to 270 ten years later, and up to 488 in 1976.

In addition to Oakland, Washtenaw, Wayne and Macomb, the following counties had a large jump in the number of physicians; and some, like Emmet, had a large percentage gain.

County	1961	1976
Berrien	108	174
Emmet	27	71
Genessee	309	465
Grand Traverse	77	109
Ingham	248	457
Kalamazoo	199	377
Kent	427	640
Marquette	48	81
Midland	42	95
Muskegon	118	131
Ottawa	61	102
Saginaw	153	252
St. Clair	69	103

It is important to note that Oakland, Washtenaw, Wayne, Macomb and other counties with residency training programs experienced quite a jump in figures when the state attorney general ruled late in 1972 that American citizenship was no longer a requirement for full licensure in Michigan. Approximately 850 temporary licenses were converted between November 1972 and June 1973 to permanent licenses.

(Continued on page 360)

"...Sleep that knits up the ravell'd sleave of care..."

—WILLIAM SHAKESPEARE, *MACBETH*, ACT II, SC. 2

Insomnia
a shade of blue that often accompanies depression

And, in anxiety/depression, Adapin® (doxepin HCl) often helps restore disturbed sleep patterns, such as early morning awakening, with a single daily dose at bedtime.[1] Adapin quickly relieves the patient's anxiety, gradually brightens his mood and outlook, with optimal antidepressant response usually evident within two to three weeks.

---

[1] Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information
ADAPIN® (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, or on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

In patients who may use alcohol excessively potentiation may increase the danger inherent in any suicide attempt or overdosage.

Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 10 mg to 25 mg t.i.d. Increase or decrease the dosage according to individual response. **Usual optimum daily dosage is 75 mg to 150 mg** per day, not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

How Supplied—Each capsule contains doxepin, as the hydrochloride: 10 mg, 25 mg and 50 mg capsules in bottles of 100 and 1000.

For complete prescribing information please see package insert or PDR.

When they see life in shades of blue... help them see life in all its colors.

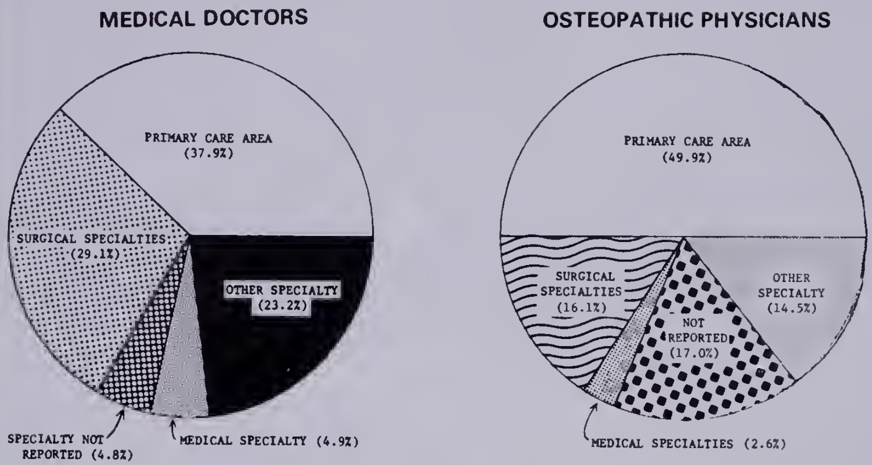
Adapin®
(doxepin HCl)

single daily dose recommended h.s.

10-mg capsules
25-mg capsules
50-mg capsules

PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester, New York 14603



A. PERCENT DISTRIBUTION OF ACTIVE PHYSICIANS ACCORDING TO PRINCIPAL SPECIALTY MICHIGAN 1976

Highlights of data from Michigan Information System

In 1976, there were 11,237 Michigan licensed MD's and 2,134 Michigan licensed DO's in the state, giving a total of 13,370 physicians.

Based on the data from physicians who responded to the survey:

- More than 90 percent of the physicians report full-time activity, with more than 66 percent of active physicians spending 40 or more hours a week in patient care.
- 37.9 percent of the MD's report a primary care area as their principal specialty.
- About 60 percent of all active physicians practice in southeastern Michigan (Health Service Area I) which includes the Detroit metropolitan area.
- At least 60 percent of the active MD's were educated in the United States.
- Of the MD's, approximately six percent are female and 11 percent are non-white.
- 59.2 percent of the active MD's are self-employed.

More details:

In 1976 there were 11,237 Michigan licensed medical doctors in the state. There were 4,431 additional M.D.'s who held Michigan licenses, but are located outside the state. Of those in Michigan, 94.9 percent replied to the survey.

Table A gives percent distributions of all licensees by sex and by race.

Table A

Percent Distribution of Medical Doctors According to Sex and to Race Michigan 1976

	Number	Percent
All Licensees	11,237	100.0
Male	8,402	74.8
Female	638	5.7
Sex Not Reported	2,197	19.6
White	7,709	68.6
Non-White	1,213	10.8
Race Not Reported	2,315	20.6

Data by sex and race must be considered with caution, because of the large proportions in the "Not Reported" categories. Distributions by broad age groups are given in Table B for those M.D.'s reporting sex and race.

The survey response indicates that 41.9 percent of the females were under 40 years of age, compared with 27.6 percent of the males. Over half (54.7 percent) of the non-white M.D.'s are under 40, compared with one quarter (24.4 percent) of the white M.D.'s.

For all licensed M.D.'s up to age 65, more than 90 percent are active full-time. At ages 60 and over, full-time activity decreases and part-time activity increases. At ages 70 and over, 75.1 percent of the M.D.'s report either full or part-time activity.

This age pattern varies by sex. The male M.D.'s have a higher proportion active full-time at each age group than do the females. When full-time and part-time activity are considered together, the figures for males and females are comparable for ages up to 60. After age 60, the males have a higher proportion active than do the females. (Figure B)

Whites and non-whites appear to have similar proportions active in each age group with some indication that for ages 55 and over, a higher proportion of non-whites remains active.

About 35 percent of all the active M.D.'s were educated in Michigan. More than half (57.5 percent) of these are University of Michigan graduates and 40.6 percent hold Wayne State degrees.

(Continued on page 363)

Natural balance
doesn't always come naturally

Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

Most Widely Prescribed—Antivert is the most widely pre-ribed agent for the management of vertigo* associated with seases affecting the vestibular system such as Menière's disease, ɔyrinthitis, and vestibular neuronitis.

Relief of Nausea and Vomiting—Antivert/25 can relieve the ɩusea and vomiting often associated with vertigo.*

Dosage for Vertigo*—The usual adult dosage for Antivert/25 ɔne tablet t.i.d.

ɪEF SUMMARY OF PRESCRIBING INFORMATION

INDICATIONS. Based on a review of this drug by the National Academy of ɩciences—National Research Council and/or other information, FDA has classified he indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with ɲotion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the ·estibular system.

Final classification of the less than effective indications requires further ɲvestigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25

(meclizine HCl) 25 mg. Tablets
for vertigo*

Upjohn
The Upjohn Company, Kalamazoo, Michigan 49001

Medrol® 4 mg Dosepak*

methylprednisolone, Upjohn

The explicit printed dosage instructions that accompany each Dosepak make it easy for the patient to understand and follow the dosage regimen.

PUSH IN AND
← SLIDE →

*Trademark

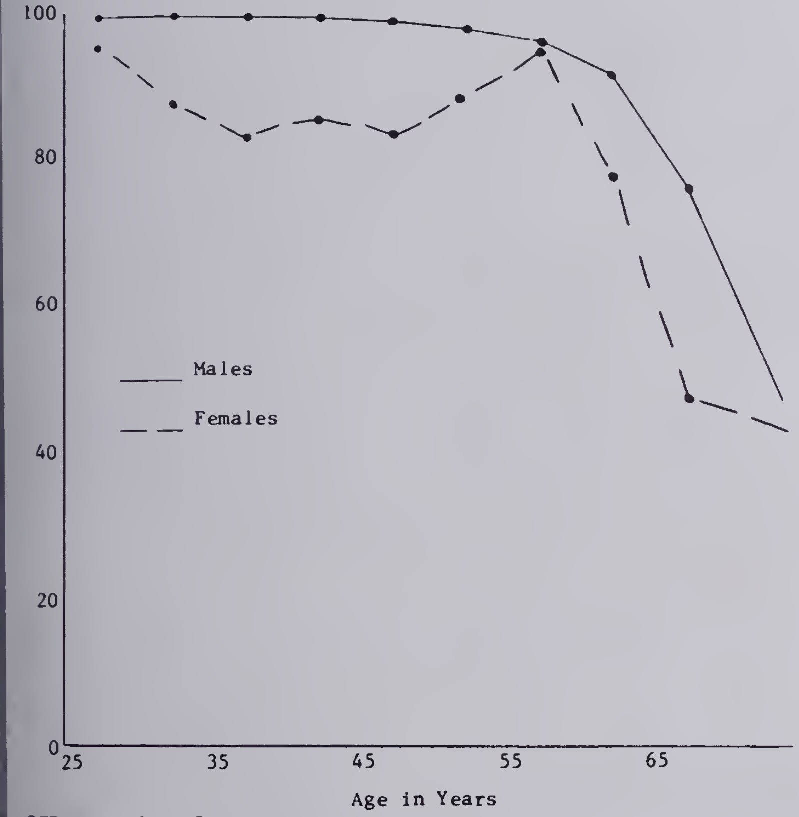
J 5741-4

©1977 The Upjohn Comp

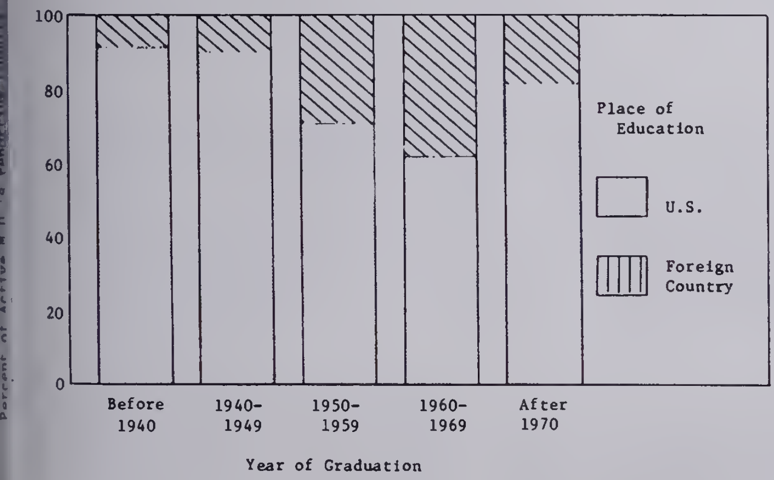
Table B

Percent Distributions of Medical Doctors By Sex and by Race, According to Age Michigan 1976

Licensees	Number	All Ages	25-39 years	40-59 years	60 years and older	Not Reported
				(Percent Distribution)		
Male	8,402	100.0	27.6	48.1	21.0	3.3
Female	638	100.0	41.9	40.2	13.5	4.5
White	7,709	100.0	24.4	49.6	22.8	3.2
Non-white	1,213	100.0	54.7	32.8	10.4	2.1

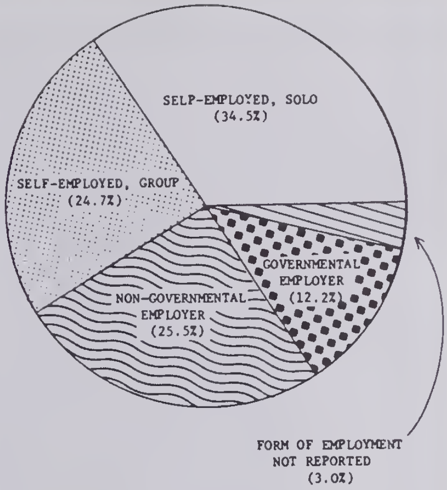


PERCENT OF MEDICAL DOCTORS ACTIVE FULL TIME, FOR EACH AGE GROUP



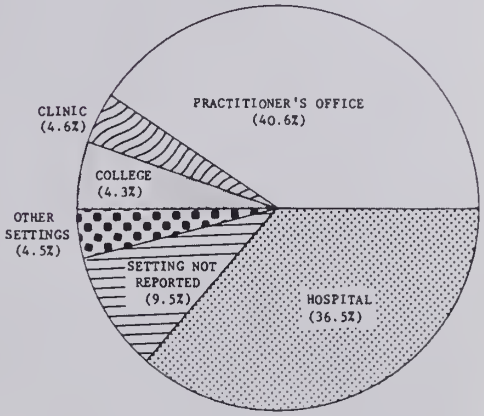
C. PERCENTAGE OF ACTIVE MDs BY GEOGRAPHIC PLACE OF EDUCATION, FOR EACH YEAR OF GRADUATION

MICHIGAN 1976



D. PERCENT DISTRIBUTION OF ACTIVE MDs BY PRINCIPAL FORM OF EMPLOYMENT

MICHIGAN 1976



E. PERCENT DISTRIBUTION OF ACTIVE MDs BY PRINCIPAL WORK SETTING

MICHIGAN 1976

Among the active M.D.'s, 37.9 percent reported a primary care area as their principal specialty, 29.1 percent reported surgical specialties, 4.9 percent reported medical specialties, 23.2 percent, other specialties, and 4.8 percent did not report a specialty.

M.D.'s involved in surgical specialties reported spending more hours per week in patient care than did M.D.'s in the other specialty groups. Seventy-nine percent of those in internal medicine report spending 40 or more patient care hours per week.

Medical students get acquainted with a young patient during pediatric rounds at C.S. Mott Children's Hospital, U-M Medical Center.

Michigan medical education program figures

By Herbert A. Auer, Manager
Dept. of Communications and CME Programming

MSMS members often write or phone to ask for information about medical schools, graduate training programs, physician's assistants, etc.

The following is intended to provide statistics to help MSMS members discuss these matters with associates and friends. The information is all from the 1975-76 Annual Report by the AMA of "Medical Education in the United States." The report appeared in JAMA, December 27, 1976.

Section C

On this and succeeding pages information is presented to help MSMS members discuss the statistics involving Michigan medical schools, graduate training programs, physicians' assistants and other matters.

Medical School Enrollments: (Michigan and National figures)

In the nation in 1975-76 the following figures report on students in medical schools:

11,695	**First-year men**
3,656	**First-year women**
21,661	**Intermediate men**
5,671	**Intermediate women**
11,361	**Men graduates**
2,200	**Women graduates**
56,244	**Total enrolled**

The word "intermediate" describes medical students who were not first-year students or who did not graduate that year.

The figures for the three Michigan medical schools were as follows for 1975-76:

	MSU	U-M	WSU	TOTAL
First-year men	65	175	205	445
First-year women	40	72	56	168
Intermediate men	136	365	443	944
Intermediate women	87	111	81	279
Men graduates	65	181	209	455
Women graduates	24	43	30	97
TOTAL	417	947	1,024	2,388

Of the first-year students, 563 of the 613 in the three Michigan schools were from Michigan for the seven
best home-state statistics.

Undergraduate Medical Educatio
(National figures)

As of October 1976 there were 1
US schools and 16 Canadian scho
accredited to award the MD degre

Total enrollment in the 114 medi
schools in 1975-76 was 56,244, an
crease of 2,170 over the previous ye

First-year enrollment increas
from 14,963 in 1974-75 to 15,351
1975-76. The number of graduates
creased from 12,714 to 13,561.

A graduating class well in excess
15,000 may be expected by 1978.

The number of women, 9,575
1975-76, was the highest yet record
as was the percentage (22.6%). Of t
women applicants, 38% were accep
as against 35% for the men.

There is no way of determining
number of Americans studying o
side the United States, Canada, a
Puerto Rico. Enrollment in fore
medical schools has become an
creasingly elected alternative for
termined US students unable to g
admission to an American school.

Almost all American stude
studying abroad plan to return to
US to practice medicine.

Of the total number of entering s
dents, 90.3% had completed four
more years of college, 8.2% comple
three years, and 1.5% completed t
years of college. Baccalaureate
grees were held by 84.1% of the s
dents, the master's by 6%, the d
torate by 1.2%, other degrees by 1,
and 7% of the students held no degr

raduate Medical Education: National and Michigan)

In Michigan, 29 hospitals offered 17 approved intern programs in 974-75. There were 522 positions of- ered. A total of 488 positions were illed for 93%. Of the interns on duty n Michigan in 1974-75, 57% were merican-trained and 43% were from oreign medical schools.

Regarding residency programs in Iichigan, 73 hospitals had 193 ap- roved residency programs in 1974- 5. A total of 2,551 positions were of- ered and 3,283 or 89% were filled. Of he residents, 55% were from US and anada schools and 45% were from oreign medical schools.

llied Health Education Programs: Michigan and National)

In 1976, the following allied health ducation programs in Michigan have een accredited by the AMA:

2	**Assistant to the primary care physician**
2	**Cytotechnologist**
0	**Electroencephalographic technician**
0	**Electroencephalographic technologist**
1	**Histologic technician**
0	**Laboratory assistant**
3	**Medical assistant**
0	**Medical assistant in Pediatrics**
1	**Medical laboratory technician**
1	**Medical record administrator**
4	**Medical record technicians**
36	**Medical technologists**
3	**Nuclear medicine technologists**
3	**Occupational therapist**
0	**Operation room technician**
0	**Ophthalmic Medical assistant**
2	**Physical therapist**
3	**Radiation therapy technologist**
35	**Radiologic technologist**
6	**Respiratory therapist**
2	**Respiratory therapy technician**
8	**Specialist in blood bank technology**
0	**Surgeon's Assistant**
0	**Urologic physician's assistant**
112	**TOTAL in Michigan**

Of the 2,742 allied health education programs accredited by the AMA in the USA, nearly two-thirds of the programs are taught in hospital or clinical settings.

As of August 1976 there are 29 organizations collaborating with the AMA, which sponsor 16 review committees to accredit educational programs for 24 allied health occupations.

Nearly half of the graduates of the AMA accredited allied health programs are in radiologic or medical technology.

Foreign Medical Graduates: (National)

During the past decade the rate of increase in foreign medical graduates (FMG's) in the United States has been three times greater than the increase in the total number of physicians in the United States. Foreign medical graduates now comprise almost 22% of all physicians in the United States. In the five-year period 1970-74 approximately two in five of the medical school graduates added to the licensure registries for physicians in the separate states were alumni of other than U.S. schools.

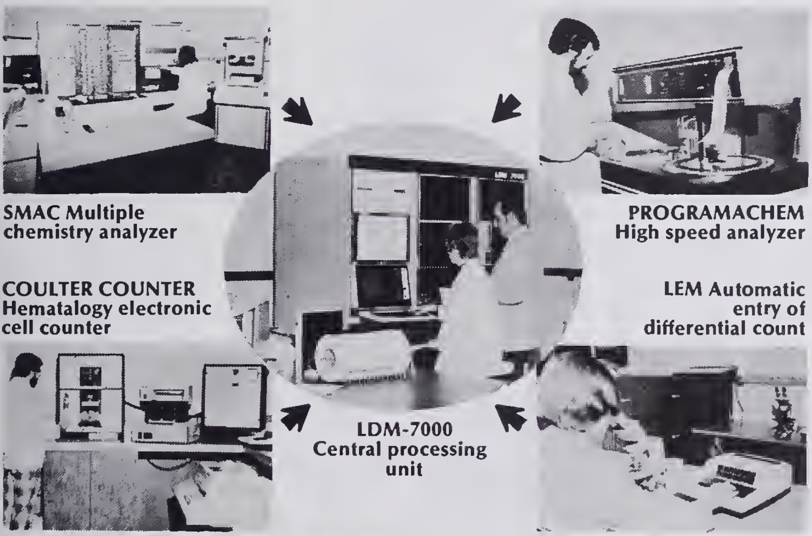
In Michigan, with the new MD licentiates added to the medical profession in 1974, the breakdown of U.S. graduates and FMG's was as follows:

348 USMG's	**(or 36.8 per cent)**
597 FMG's	**(or 63.2 per cent)**
945 TOTAL	

The same breakdown for all states was as follows:

10,093 USMG's	**(or 60.4 per cent)**
6,613 FMG's	**(or 39.6 per cent)**
16,706 TOTAL	

* AMRC Computerized Laboratory *


SMAC Multiple chemistry analyzer
PROGRAMACHEM High speed analyzer
COULTER COUNTER Hematalogy electronic cell counter
LEM Automatic entry of differential count
LDM-7000 Central processing unit

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Actions of the Michigan Medical Practice Board

By Sherry Wellman, MSMS Government Agency Liaison

The following disciplinary actions of the Medical Practice Board are presented here as a matter of public record. The language used is taken directly from the official notifications of the Medical Practice Board and is not editorialized.

1. Albert Lucian Laura, MD, Livonia, MI. An order of summary suspension was issued on March 2, 1977 by the Michigan Medical Practice Board. The complaint was based on paragraph 2 of the complaint which states: The Medical Practice Board is authorized by section 11 of 1973 PA 185, *supra*, to take disciplinary action against a licensee pursuant to said section for failing to use reasonable care and discrimination in the administration of drugs; failing to employ acceptable scientific methods in the selection of drugs and other modalities for treatment of disease; selling, prescribing, giving away or administering drugs for other than legal and legitimate therapeutic purposes; departing from or failing to conform to minimal standards of acceptable and prevailing medical practice; and unprofessional conduct within the meaning of section 11(b)(c)(i)(r) of 1973 PA 185, *supra*, as more particularly set forth hereinafter. It is hereby ordered that based upon said complaint and supporting affidavits the continued ability of Albert Lucian Laura, MD to continue to act as a medical physician and surgeon in the State of Michigan constitutes an imminent danger to the public health, safety and welfare requiring emergency action.

A watercolor fantasy of over 30 Michigan wildflowers, painted by East Lansing artist Margot Evans, was the special award made by the Michigan Association of the Professions recently to retiring U.S. Senator Robert Griffin of Traverse City. The presentation was made by MAP President George W. Slagle, MD, Battle Creek, left, in Sen. Griffin's Washington, DC office. The painting was given by MAP to recognize Sen. Griffin's distinguished service, and was inscribed, "of all professional persons, he has served the professions best, 1976 AD."

2. Hugo R. Saenz, MD, Lansing, MI. At a regularly convened meeting of the Medical Practice Board on April 7, 1977, after due consideration, the Board issued a letter of reprimand for alleged violation of the Medical Practice Act, i.e., respondent departed from minimal standards of practice; in violation of section 11(1) of the Act.

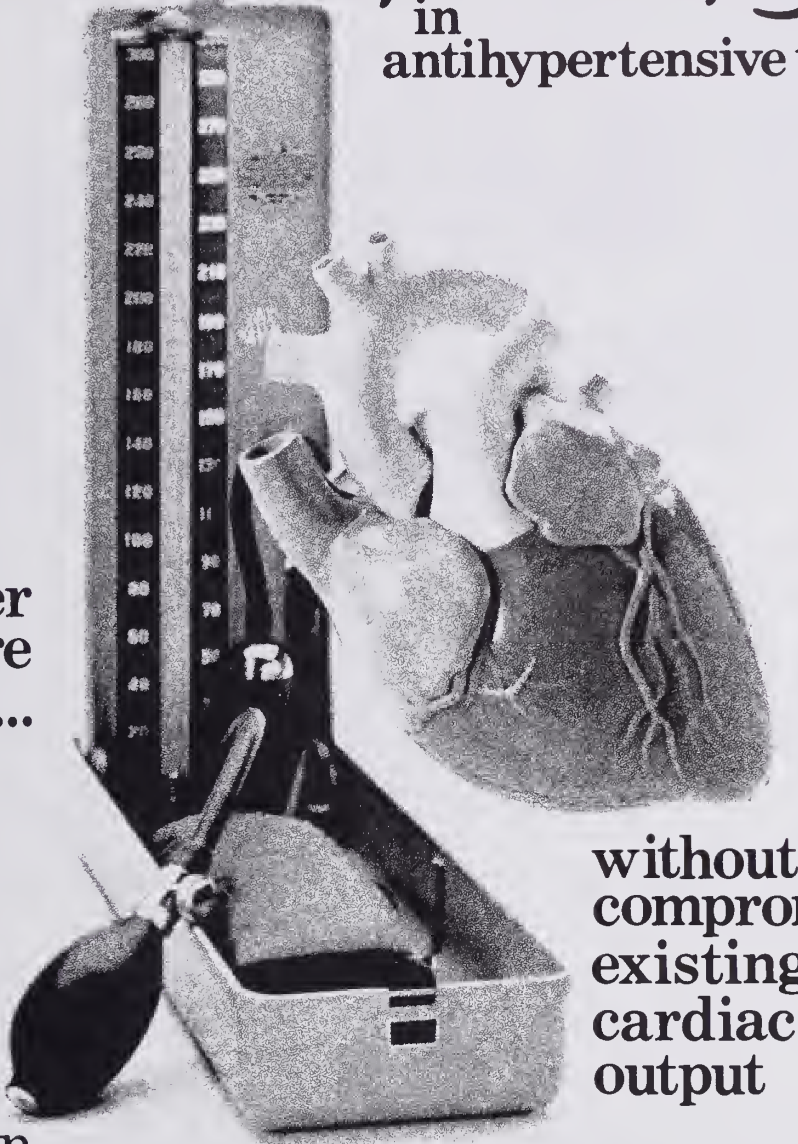
3. Robert Henri Hydrick, MD, Grand Rapids, MI. The members of the Michigan Medical Practice Board have taken the following disciplinary action April 7, 1977. Michigan medical license was suspended for 12 months by the Michigan Medical Practice Board for being found guilty of violation of the Medical Practice Act 1973, PA 185 as amended, section 11(b)(e)(i) and section 12(1) of the Act. Effective date of suspension is May 31, 1977.

4. Charles J. Danek, MD, Ann Arbor, MI. At a regularly convened meeting on April 7, 1977, the Michigan Medical Practice Board, after due deliberation, issued an order of a limited license for alleged violation of the Medical Practice Act, 1973 PA 185, as amended, i.e., licensee prescribed drugs for other than a legal and legitimate therapeutic purpose or departs from or fails to conform to minimal standards of acceptable and prevailing medical practice in violation of section 11 of the Act. Effective date, April 11, 1977.

5. Bruce K. Clark, MD, Temperance, MI. On May 4, 1977, at a regularly convened meeting and after due deliberation, the Michigan Medical Practice Board issued an order of summary suspension for alleged violation of the Medical Practice Act, 1973 PA 185, as amended, i.e., licensee accused of immoral conduct, unprofessional conduct, inability to practice medicine as a result of a mental or physical condition. Effective date of the order, May 4, 1977.

Note: Members of the Michigan State Medical Society who have their medical licenses suspended by the Michigan Medical Practice Board are automatically dropped from membership in MSMS and the component medical society.

A Dual Challenge
in
antihypertensive therapy



to lower
blood pressure
effectively...

without
compromising
existing
cardiac
output

in hypertension

TABLETS: 250 mg, 500 mg, and 125 mg

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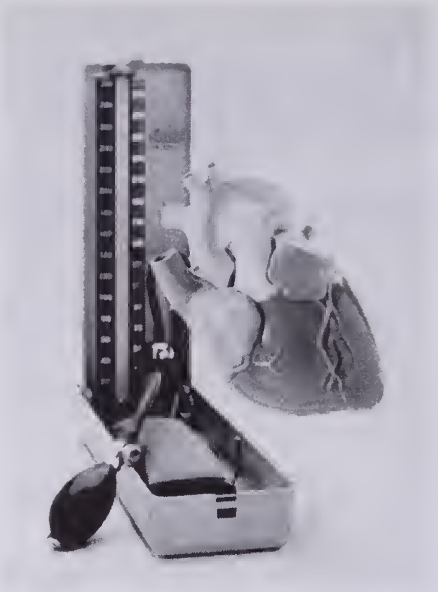
helps lower blood pressure effectively...
usually with no direct effect on
cardiac function–cardiac output
is usually maintained

ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyldopa therapy has been associated with liver disorders.
It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

For a brief summary of prescribing information, please see following page.

MSD
MERCK
SHARP&
DOHME



in hypertension

ALDOMET®

(METHYLDOPA|MSD)

helps lower
blood pressure
effectively...
usually with no
direct effect on
cardiac function–
cardiac output is
usually maintained

Contraindications: Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity.

Warnings: It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

Use in Pregnancy: Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

Precautions: Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of: uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic moven
occur in patients with severe bilateral cerebrov
lar disease. Patients may require reduced dos
anesthetics; hypotension occurring during
thesia usually can be controlled with vasopres
Hypertension has recurred after dialysis in pat
on methyldopa because the drug is removed b
procedure.

Adverse Reactions: *Central nervous sy*
Sedation, headache, asthenia or weakness, u
early and transient; dizziness, lightheaded
symptoms of cerebrovascular insuffici
paresthesias, parkinsonism, Bell's palsy, decr
mental acuity, involuntary choreoathetotic
ments; psychic disturbances, including nightr
and reversible mild psychoses or depression.
Cardiovascular: Bradycardia, aggravation of a
pectoris. Orthostatic hypotension (decrease
dosage). Edema (and weight gain) usually re
by use of a diuretic. (Discontinue methyldc
edema progresses or signs of heart failure ap
Gastrointestinal: Nausea, vomiting, distention
stipation, flatus, diarrhea, mild dryness of mout
or "black" tongue, pancreatitis, sialadenitis.
Hepatic: Abnormal liver function tests, jau
liver disorders.
Hematologic: Positive Coombs test, he
anemia. Leukopenia, granulocytopenia, t
bocytopenia.
Allergic: Drug-related fever, myocarditis.
Other: Nasal stuffiness, rise in BUN, breast e
ment, gynecomastia, lactation, impotence, dec
libido, dermatologic reactions including eczem
lichenoid eruptions, mild arthralgia, myalgia.

Note: Initial adult dosage should be limit
500 mg daily when given with antihyperte
other than thiazides. Tolerance may occur, u
between second and third month of therap
creased dosage or adding a thiazide freq
restores effective control. Patients with im
renal function may respond to smaller doses
cope in older patients may be related to inc
sensitivity and advanced arteriosclerotic va
disease; this may be avoided by lower doses

How Supplied: Tablets, containing 1
methyldopa each, in bottles of 100; Tablets, c
ing 250 mg methyldopa each, in singl
packages of 100 and bottles of 100 and
Tablets, containing 500 mg methyldopa ea
single-unit packages of 100 and bottles of 1
For more detailed information, consult you
representative or see full prescribing in
tion. Merck Sharp & Dohme, Division of M
Co., Inc., West Point, Pa. 19486 J6AM07

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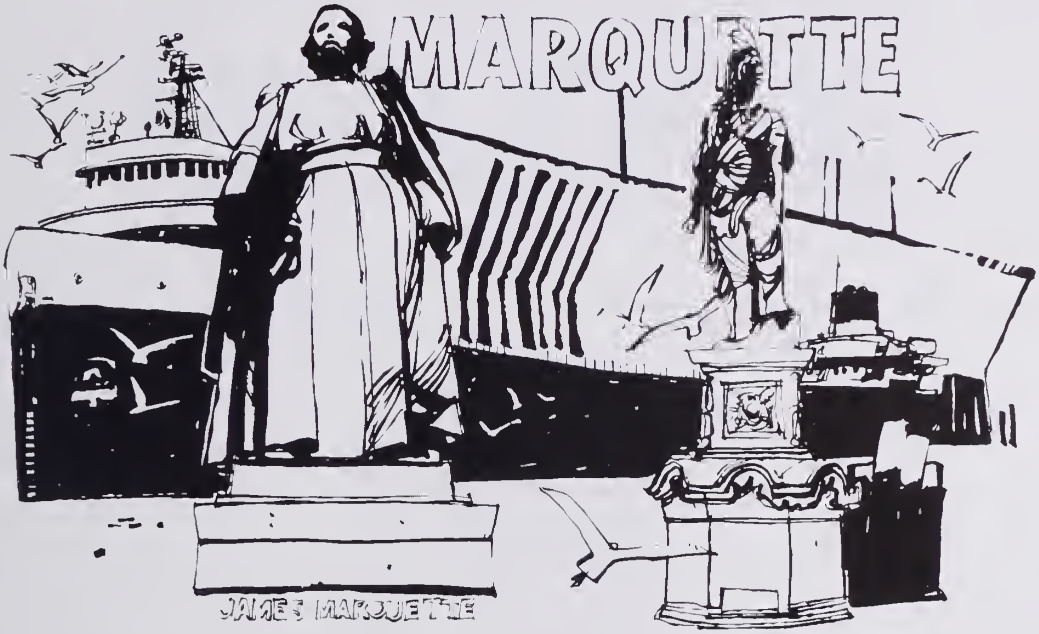

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- Practical Management of Hypertension
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(please print or type)
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Office Phone No. (   ) ______________________

Short-term investments which earn well for the physician

By David M. Buegeleisen
Southfield

In every medical practice there are times when funds accumulate which are not needed for the day-to-day expenses. For instance, monies may be set aside to pay future taxes or set aside to meet forthcoming expenses. These funds can be invested to earn income.

Since they will probably be disbursed in a relatively short period of time, it is essential that only the safest, most liquid, investment vehicles be used.

The simplest and safest of all available investments is a savings account. Although banks accept savings accounts from corporations, the rate of interest that they are currently paying is ½ of 1% below the rate paid by savings and loan associations. As savings and loan deposits are insured by an agency of the United States Government up to the amount of $40,000, these deposits are as safe as any bank deposit to that amount. Many savings and loan associations now have telephone transfer of funds. Where telephone transfer of funds is available, all one needs to do is write a check for deposit in savings and loan. When the funds are needed, a telephone call to the savings and loan transfers the funds on the same day into the bank checking account. Most savings and loan associations are now paying 5¼% interest from date of deposit to date of withdrawal.

Mr. Buegeleisen is an investment counselor.

Other short term investment vehicles are treasury bills and commercial paper. Treasury bills are short-term obligations of the United States Treasury and are issued for up to one year. They generally pay interest at a higher rate than savings accounts although there are times when this is not the case. Currently, treasury bills are not particularly attractive, vis-a-vis savings acounts, but in times of rising interest rates they may yield much more than savings accounts do. They are usually bought and sold through banks which charge a small service fee for handling. Treasury bills are traded in multiples of $5,000. They are not particularly attractive when sums smaller than $20,000 are involved.

Commercial paper is a short-term obligation of a large corporation. Like treasury bills, it is issued for periods of up to one year. At this time, the yield is not sufficient to warrant use of commercial paper. But like treasury bills, the paper yield is often very much higher in times of rising interest rates. The undisputed highest quality commercial paper is that issued by Sears Roebuck and Company. It is a direct obligation of Sears, while commercial paper issued by most other corporations is the obligation only of a financial subsidiary. Also of high quality are General Motors Acceptance Corporation, Ford Motor Credit and General Electric Credit. A buyer of commercial paper should be particularly careful - buying nothing but the Paper of the highest-rated corporations.

In terms of quality and certainty of payment, savings acounts are the surest investment and probably the simplest from the administrative viewpoint. At the present time they offer the most attractive vehicle for investing surplus funds.

From time to time a professional corporation will put aside funds for some future project and these funds will not be needed for several years. Examples of this type of provision are: Savings for a new building; purchase of new equipment; or for the opening of a second office. For example: A radiology group decides to purchase a CT Scanner but will not get delivery for three years. During these three years they expect to accumulate the bulk of the money needed for the purchase. In situations such as these, high-quality preferred stocks offer a particularly advantageous investment, as the dividend on these preferred stocks is 85% tax-free to the purchasing corporation. This is true for almost all preferred stocks. Care should be exercised at the time of purchase to ascertain whether any particular issue meets this qualification.

At the present time high-quality preferred stocks are yielding approximately 8.5%. With the dividend exclusion, the after-tax yield to the professional corporation would be 7.73%. Great care must be exercised in the selection of preferred stocks as only the highest-quality issues with excellent marketability should be considered. While it is possible for preferred stocks to lose value, their fluctuations generally are small and in line with interest rates - moving up in price when interest rates fall and losing value when interest rates rise.

Because the tax laws place a penalty on any corporation building up excess funds beyond their needs, the use of preferred stock investments are not practical unless a corporation can demonstrate to the Internal Revenue Service that the accumulated funds are being set aside for some future project. Before any program involving the use of Preferred Stocks is initiated, consultation with tax counsel is strongly advised.

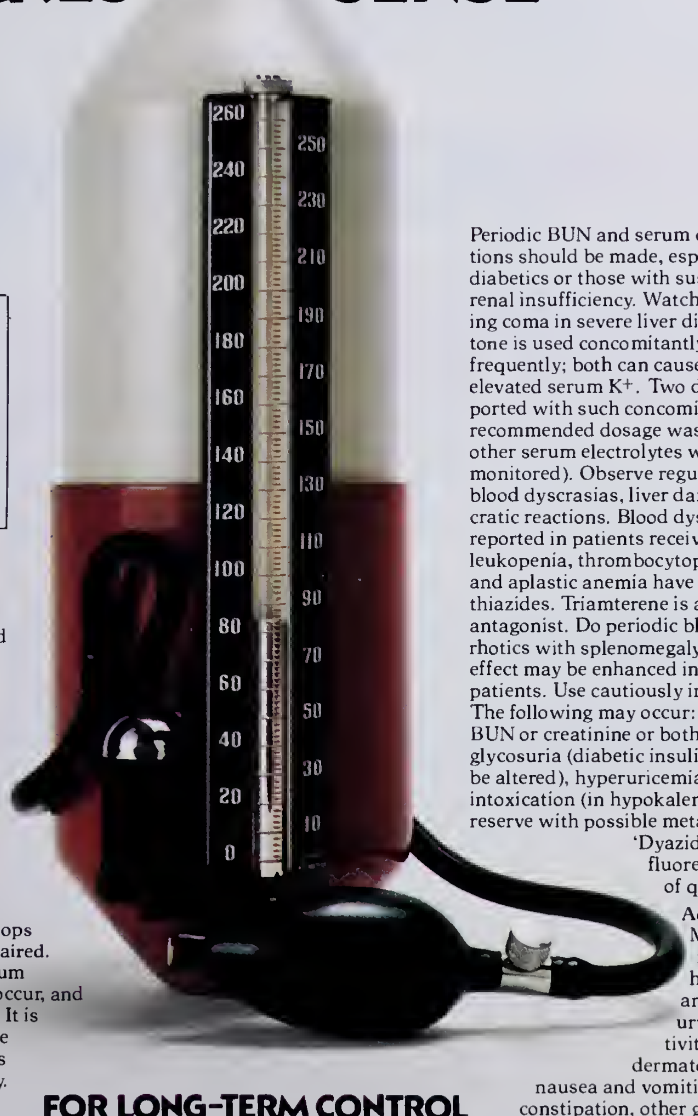
The 85% dividend exclusion is available only to corporations. For solo practitioners and partnerships, savings accounts, treasury bills, and commercial paper are the best repository for surplus funds.

TRIAMTERENE CONSERVES POTASSIUM WHILE HYDROCHLOROTHIAZIDE LOWERS BLOOD PRESSURE

DYAZIDE®

Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

> Warning
> This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Indications: When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis.

'Dyazide' interferes with fluorescent measurement of quinidine.

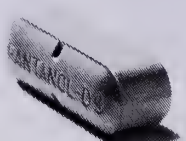
Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION:*
SERUM K+ AND BUN SHOULD BE CHECKED PERIODICALLY.
(SEE WARNINGS SECTION.)

SK&F CO., Carolina, P.R. 00630

SK&F CO.
a SmithKline company



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sulfamethoxazole/Roch

**double-strength dosage form
for acute cystitis* patients**

*nonobstructed; due to susceptible organisms

/ Gantanol® DS (sulfamethoxazole) tab-
offer even greater convenience and
nomy for your patients with acute,
obstructed cystitis due to susceptible
ins of *E. coli, Klebsiella-Aerobacter,*
hylococcus, *Proteus mirabilis* and,
frequently, *Proteus vulgaris*...
same amount of medication, the same
acy, with only *half* the number of tablets
day.
lified dosage regimen encourages pa-
compliance: 2 tablets (1 Gm each)
T—then 1 tablet B.I.D. for 10 to 14 days.
ical efficacy so basic you can start cys-
therapy even before culture results are
lable.

- In a clinical study of 406 patients on Gantanol (sulfamethoxazole) B.I.D., close to 9 out of 10 patients achieved negative urine cultures. While Gantanol tablets were used in this study, one Gantanol DS tablet has been proved bioequivalent to two Gantanol tablets.*

Gantanol is contraindicated during pregnancy, during the nursing period, and in infants under 2 months. During therapy, maintain adequate fluid intake, perform frequent CBC's and urinalyses with careful microscopic examination.

*Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey.

nd economy

e prescribing, please consult complete product
nation, a summary of which follows:
ations: Acute, recurrent or chronic urinary tract infec-
(primarily pyelonephritis, pyelitis and cystitis) due to
ptible organisms (usually *E. coli, Klebsiella-Aerobacter,*
ylococcus, *Proteus mirabilis* and, less frequently,
s vulgaris), in the absence of obstructive uropathy or
n bodies. Note: Carefully coordinate *in vitro* sul-
ide sensitivity tests with bacteriologic and clinical
nse; add aminobenzoic acid to follow-up culture
. The increasing frequency of resistant organisms
the usefulness of antibacterials including sul-
ides, especially in chronic or recurrent urinary tract
ions. Measure sulfonamide blood levels as variations
ccur; 20 mg/100 ml should be maximum total level.
aindications: Sulfonamide hypersensitivity; preg-
at term and during nursing period; infants less than
onths of age.
ings: Safety during pregnancy has not been estab-
. Sulfonamides should not be used for group A
emolytic streptococcal infections and will not eradi-
r prevent sequelae (rheumatic fever, glomerulone-
) of such infections. Deaths from hypersensitivity reac-
agranulocytosis, aplastic anemia and other blood
asias have been reported and early clinical signs
throat, fever, pallor, purpura or jaundice) may indi-
erious blood disorders. Frequent CBC and urinalysis
icroscopic examination are recommended during
amide therapy. Insufficient data on children under
h chronic renal disease.
utions: Use cautiously in patients with impaired renal
atic function, severe allergy, bronchial asthma; in glu-
6-phosphate dehydrogenase-deficient individuals in
dose-related hemolysis may occur. Maintain ade-
fluid intake to prevent crystalluria and stone formation.
se Reactions: *Blood dyscrasias* (agranulocytosis,
ic anemia, thrombocytopenia, leukopenia, hemolytic
a, purpura, hypoprothrombinemia and methemo-
iemia); *allergic reactions* (erythema multiforme, skin
ons, epidermal necrolysis, urticaria, serum sickness,

pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis). *Usual adult dosage:* 2 Gm (2 DS tabs or 4 tabs or 4 teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially; then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

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Detroit Medical Center nearing 1978 completion

By C. R. Shelton
Special to **Michigan Medicine**

All construction currently planned for the Detroit Medical Center, except for parking decks and a tunnel connecting buildings, should be completed in 1978.

Building activity there now includes the University Clinics Building, which should open in mid-1978; the new Detroit General Hospital, scheduled for occupancy the end of that year; Hutzel Hospital's addition; a tunnel beneath Brush Street, and a central radiation therapy facility between the University Clinics Building and Children's Hospital.

The 100-acre, $500,000,000 project has progressed approximately on schedule.

One of the largest medical centers in the nation, DMC literally has rebuilt an area bounded by Woodward, the Chrysler Freeway, Warren and Mack streets. New structures include a medical school, campus, modern hospitals, office buildings, and housing for medical personnel.

Some history

It all began back in the 1940's when Harper, Grace, Children's and Woman's (now Hutzel) Hospitals, who shared inadequate facilities, and location in a declining area, considered a move to the suburbs.

The hospitals decided instead to stay, to refurbish, remodel, or rebuild. The Hospital Area Improvement Association was formed.

In 1956, the Medical Center Citizens Committee unveiled master plans for the health complex before the Detroit City Commission. The City adopted a Medical Center Renewal Plan which provided the needed acreage.

The Federal government, late in 1956, offered its support of the plan in the form of $30,000,000, and by 1962, ground was broken for construction of a medical research building. Wayne State University joined the Medical Center when it was decided that the University should use existing institutions in close proximity to its new medical campus.

According to Jacques Cousin, president of Detroit Medical Center Corporation, there are no problems involving construction now underway, although some institutions in the Center have borrowed heavily.

Challenges yet

There are, however, various things the Center needs for which financing probably would be difficult right now.

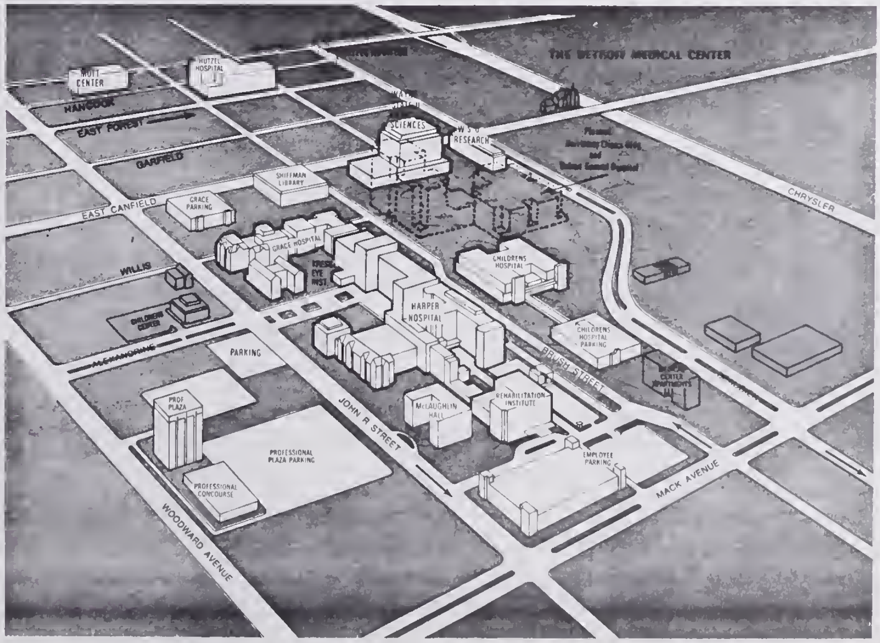
One of the most pressing needs is a transportation system to move patients and employees from one hospital to another, and back and forth from the parking lots.

Another challenge has been controlling costs in an environment which gives health care to a large number of patients and provides the bulk of teaching beds for Wayne State University's Medical School.

Costs at the Center — because of combining health care and teaching — are somewhat higher than at facilities which offer health care only. And there are those who argue that health care and teaching do not necessarily belong together.

However, Mr. Cousin states that because of the Center's health education efforts, patients probably receive better care, even though someone must pay for education expenses.

Another major challenge which originally faced the Center has been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DMC / *Continued*

met and handled successfully. When the medical center concept was announced, many people in the neighborhood felt it was a project that would tear down houses and uproot people. But neighbors in the area have come to see the Center as a stabilizing influence; one that is attractive and almost insures stability of property values.

Agreement that the Center is a good thing for the area was demonstrated recently when plans to close Brush Street and build a tunnel under it were presented to a Citizen's District Council. The project was approved in one, rather short, evening meeting, with no real opposition voiced against it.

Saving costs

One of the strong points of the Medical Center is its ability to effect cost containment through shared services.

Thanks to the shared purchasing program, the Center achieved a savings of 13% this year on items such as drugs, milk, ice cream, linens, paper, and trash bags.

Other savings are made by the operation of a central laundry and central medical transcription system, used, to date, only by Children's and Harper hospitals. Dictation goes, via telephone, to a bank of typists who transcribe medical records at a central location.

A central, wide-area paging system that reaches physicians as far away as Mt. Clemens, is operated by the Center. The Center also has one Centrex telephone network, cutting in half the number of necessary operators.

DMC has another unique possibility for lowering costs. When everything is completed, the total number of beds will have been reduced by 12%. This will hopefully increase occupancy while it reduces costs. Bed reduction is an element of the DMC's concept of "Centers of excellence."

"Centers of excellence" will concentrate talent, equipment and supplies to provide better care and medical training than otherwise possible.

Under this concept, Children's Hospital handles all pediatrics, Hutzel handles obstetrics and medical-surgical services and the University Clinics will provide care for all adult — and some children — ambulatory outpatients. Detroit General Hospital will be the major emergency and trauma care area, Harper-Grace Hospitals will become medical-surgical institutions, and the Rehabilitation Institute will concentrate on physical medicine and rehabilitation.

While hospital bed occupancy has been down throughout the state, DMC occupancy this year is about 77%, and is holding or increasing.

Safety factor

One reason for the satisfactory occupancy rate may be that DMC is reportedly one of the safest areas in Greater Detroit. According to the FBI and Detroit Police Department, the Center is safer — so far as crimes against persons are concerned — than all but two Detroit suburbs.

Safety, of course is a major concern for the more than 10,000 people who work at the center each day, and the 7,500 others who visit. A 110-person security force serves them with up-to-date law enforcement techniques.

The future of DMC is closely tied to what happens to the city of Detroit, and vice versa. Hopefully, as Detroit becomes safer and more acceptable to more people as a place to visit, bed occupancy will increase and become stable, particularly as people begin to realize that DMC is one of the choice places in the nation for medical care.

Additionally, as the energy crisis causes citizens to be concerned about long commutes, having medical care in one central location should become increasingly appealing.

And there is always the possibility that the Center will grow. The Veteran's Administration appears on the verge of replacing the hospital it operates now in Allen Park, and presently has a feasibility study underway to decide where to relocate.

Detroit Medical Center feels it is the logical place for a new VA Hospital for many reasons: one of the most important is that the Veteran's Administration and WSU's Medical School have a long history of close cooperation.

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Heartbeat

By Mert Scholten
MSMS Communications Department

John Affeldt, MD, will succeed John Porterfield, MD, as director of the Joint Commission on Accreditation of Hospitals (JCAH) on Aug. 15. Affeldt, 59, was born in Lansing, received his undergraduate degree from Andrews University in Berrien Springs and completed his internship at Detroit General Hospital. He currently is the medical director of the Los Angeles County Department of Health Services.

Theodore Bauer, MD, Lansing, was featured in the *Lansing State Journal* recently for his views on 50 years in medicine and CME. The well-known Lansing physician who will be 81 in August plans to continue his practice. Doctor Bauer likes the weekly clinics at local hospitals as a way of learning new treatment methods. The story relates how Doctor Bauer, as an intern in 1922, gave an injection of a new medication — insulin — to a diabetic near death. That patient is now the head of the U-M Department of Cardiology.

Frank J. Detterback, MD, Howell, has been named chief of clinical affairs at Hillcrest Center by the Michigan Department of Mental Health. He has been medical superintendent at the center since 1970 and has been on the staff since 1963.

Calvin H. Hughes, MD, St. Clair Shores, psychiatrist, has been appointed by Governor Milliken to the State Board for Marriage Counselors, succeeding **Dean Carron, MD, Ann Arbor**. The appointment is subject to Senate approval.

Richard Kislov, MD, Muskegon plastic surgeon, recently was awarded a silver medal in the 44th annual exhibition of the National Sculpture Society in New York City. His winning entry, a 26-inch-high bronze statue of a fat, aging wrestler, was selected from 700 entries. Each year, Doctor Kislov devotes three to four months to his avocation. "I consider it (art) my second profession," says Doctor Kislov. "It's not a hobby at all."

Clarence S. Livingood, MD, Detroit, former chairman of the Henry Ford Hospital Dermatology Department, is new member-at-large of the board of the Michigan Council of Medical Specialty Societies. Doctor Livingood is clinical professor of dermatology at the U-M; executive director, American Board of Dermatology, and member, board of trustees, the Education Council for Foreign Medical Graduates.

Kenneth K. Newton, MD, Detroit, state surgeon for the Michigan National Guard, is the first American elected to membership in the German Society for Military Medicine and Pharmacy. Active in Hutzel and Holy Cross Hospitals in Detroit, Doctor Newton (who holds the rank of colonel) has several teaching appointments through WSU and U-M medical schools and is in the private practice of internal medicine.

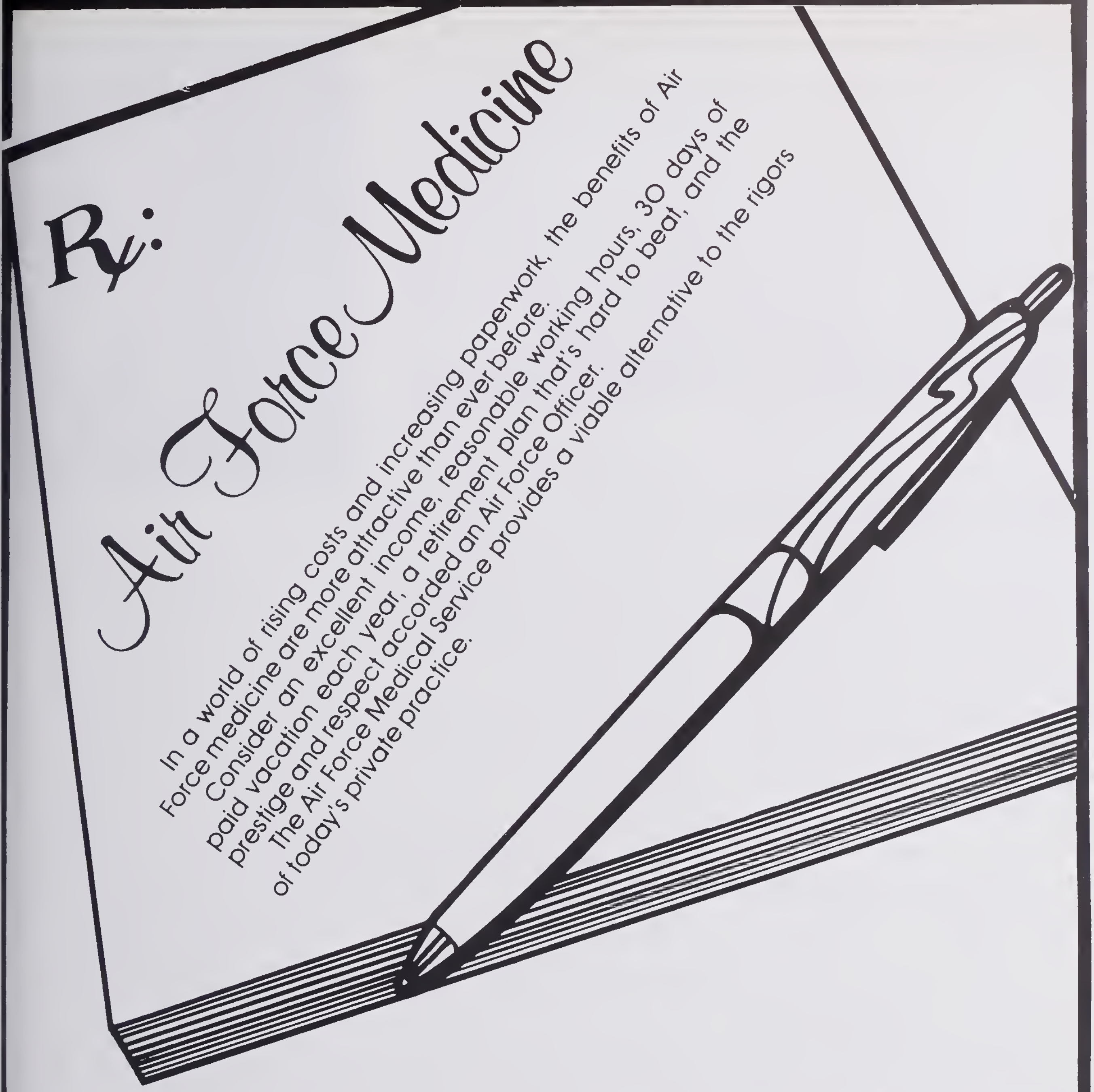
H. Marvin Pollard, MD, Ann Arbor, internationally known cancer expert, was one of 19 persons selected by the American Cancer Society to tour the People's Republic of China for one month. He was the Michigan representative.

Larry Sell, MD, Manistique, is new vice-chairman of the board of control of Northern Michigan University. A 1962 honor graduate of NMU, Doctor Sell was the first alumnus ever appointed to the university's governing body when Governor Milliken named him to an eight-year term in 1975.

Over 50 MSMS members were eligible this year to receive the MSMS award marking their 50th year since graduation from medical school.

Those present to receive pins during the 1977 MSMS House of Delegates meeting included Benjamin Brand, MD, Detroit; Gordon T. Brown, MD, Rochester; John J. Connorss, MD, Southfield; Irving E. Edgar, MD, Detroit; Willard M. Green, MD, Pontiac; Harvey C. Hansen, MD, Battle Creek; Reece H. Horton, MD, Southfield; Barney B. Israel, MD, Detroit; Paul W. Kniskern, MD, Grand Rapids; James V. Lammy, MD, Berkley; Luther Leader, MD, Bloomfield Hills; Paul J. Ochsner, MD, Lansing; Alex Olen, MD, Detroit; Alvin E. Price, MD, Detroit; Abraham S. Rogoff, MD, Southfield; Arthur M. Rothman, MD, Mt. Clemens; Raymond E. Sculley, MD, Grand Rapids; Clyde S. Tarter, MD, Alpena; R. Wallace Teed, MD, Ann Arbor, and George H. Zinn, MD, Detroit.

Others receiving 50-year pins are Mac B. Benjamin, MD, Sanford; Stuart Berrgsman, MD, New Port Richey, Fla; Harry Bishop, MD, Saginaw; Charles L. Borden, MD, Trenton; William G. Coleman, MD, Detroit; Frank J. Condon, MD, Sun City, Ariz; Ennis H. Corley, MD, Green Valley, Ariz; David B. Davis, MD, Ada; Francis B. Fralick, MD, Pinckney; Everett W. Gaikema, MD, North Muskegon; Edwin L. Harmon, MD, Grosse Pointe Park; Orville J. Hastings, MD, Detroit; Owen S. Hendren, MD, Tucson; Stacy C. Howard, MD, Winter Park; Hastings H. Huggins, MD, Detroit; Roy D. Jones, MD, Holiday, Fla; Howard J. Kerr, MD, Muskegon; Raymond J. Laige, MD, Grosse Pointe Park; David M. Levin, MD, Phoenix; Chester Lund, Phoenix; William F. Mertaugh, MD, Sault Ste. Marie; Albert W. Myers, MD, Stanton; William E. Nesbitt, MD, Alpena; L. Paul Ralph, MD, Sun City, Ariz; Arthur J. Seaborn, MD, Birmingham; John L. Siefert, MD, Jupiter, Fla; Edmond S. Socha, MD, Fort Lauderdale; Loren C. Spademan, MD, Harbor Springs; Wendell H. Stadle, MD, Sun City; Howard P. Staub, MD, Allen Park; Steven L. Van Riper, MD, Detroit, and Albert E. Vossler, MD, Ontario.



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MSMS Auxiliary aids physicians, communities

Dee McGinty

By Willah Weddon
***Special to* Michigan Medicine**

Doctor, if your wife is donating blood, selling pecans, collecting sample drugs or planning a party, she's undoubtedly a member of your County Medical Society's Auxiliary.

•Contributing blood or helping collect blood for blood banks has been one of the top priorities of the Michigan State Medical Society-Auxiliary this year.

•Profits from sales of pecans, Christmas cards and a multitude of unique projects, are turned over to the AMA-ERF to assist medical schools and students. (AMA Education Research Fund.)

• Sample drugs are picked up from medical offices and delivered by the truckload to World Medical Relief, Inc. for distribution.

•Parties promote acquaintanceship and foster better fellowship among physicians' families.

These are but a few of the projects undertaken by auxiliary members dedicated to promoting the ideals and objectives of their spouses and the medical profession. Of approximately 8,000 physicians belonging to the Michigan State Medical Society, 3,065 wives (or husbands) are auxiliary members. About half (43) of Michigan's counties have auxiliaries and 40 women are members-at-large who reside in unorganized counties.

Membership increase top priority

Dee McGinty (Mrs. John. D.) newly elected MSMS-A president, has set an increase in membership as one of her objectives during the coming year. She feels very strongly that every doctor's spouse should be an auxiliary member.

Priorities are established on the national level in conjunction with the AMA. This year the AMA Auxiliary has actively opposed violence on television programs. More than 88,000 auxiliary members in the nation have been encouraged to write letters to sponsors of programs containing violence and, in essence, boycott their products. The auxiliary's and other organizations' concerted action has resulted in sponsors taking a closer look at some of the TV programs and cancelling them.

In Michigan the state auxiliary's fundamental purpose is "to assist the MSMS in its program for the advancement of medical and health education."

During the past year, Ruth Dixon (Mrs. Willis), MSMS-A immediate past president, emphasized two concerns: Improving life for the elderly, and blood contributions. Many projects continue from year to year, such as AMA-ERF fund-raising, community health, family health and international health. These serve as guidelines and provide resources for county projects.

AMA-ERF activities furnish an example of the auxiliary's effectiveness. Macomb county, with 76 members, contributed $5,929.43 to the fund last year. Members held a "Celebrity Auction" in a joint effort with the medical society and raised more than $3,700 in one evening to bolster the total. (They received an award for their efforts at the AMA-A convention in Dallas, as a result.) Other auxiliaries raised funds by auctioning pastries, holding tennis and bridge parties, selling watches and cookbooks, setting up "traveling boutiques" or making individual cash contributions. When the counties send their funds to the national chairman, they can indicate if they want the money earmarked for a particular medical school or to go into a loan guarantee fund. Recently the University of Michigan received $13,493.25, Wayne State University $6,829.34 and Michigan State University $4,603.48, for their medical schools. In 1975, the University of Michigan was one of four schools in the nation providing the most loans to medical students (142).

Members alert to community needs

Although the national and state auxiliary objectives are promoted, county auxiliaries are free to draw up their own programs as they are approved or assigned by their county medical societies. Members are encouraged to be alert for needs peculiar to their community and, with approval, the auxiliary initiates action toward solving the problem. Not infrequently, an auxiliary leads the way by recognizing a community problem and originating a means to solve it.

"Many county concerns include senior citizen groups, scholarships or loans for students in health careers, aid to the local hospital or the Institue of Burn Medicine," Mrs. Dixon observed during her tenure in office. "Auxiliaries conduct health education classes in schools, assist with immunization programs, present "Safety Prevention" programs, staff bloodmobiles and donate blood, contribute to SKIP, (Scholarships for Kids of International Physicians), conduct classes in nutrition, sponsor the GEMS program (Good Emergency Mother Substitutes) and provide volunteers for other service groups such as Meals on Wheels for the homebound."

Among recent achievements of county auxiliaries:

- Kalamazoo County: Awarded $1,000 in scholarships to their local nursing programs.
- Muskegon County: Nine members are serving in the Meals on Wheels program, delivering hot meals to people who cannot prepare their own meals or leave their homes to get meals.
- Oakland County: Members did their grocery shopping on "Donation Day" and, as prearranged, the A & P returned five percent of the total sales to the auxiliary for a contribution to AMA-ERF.
- Jackson County: $200 has been authorized to use in making Hygiene Kits for World Medical Relief, Inc. These will be sent to Indian children in the Southwest.
- St. Clair County: Helped sponsor a Health Careers Day in Port Huron.

Legislation of high interest

Auxiliary members throughout the state are active in the field of legislation, often on an individual basis. They present an impressive lobbying force when the medical society asks for their assistance. This is handled by the MSMS-A legislative chairman, who sends out "ALERTS" to each county when the medical society (state and national) desires support in passage or defeat of a particular piece of legislation. The women write letters and letters are effective.

Many auxiliary members are active in politics and a surprisingly large number hold elective offices locally. Several serve in state-wide posts, having been appointed by Governor William G. Milliken.

An indication of the interest in politics is the continued growth of the annual Legislative Day, sponsored by the state auxiliary (with some financial assistance from MSMS, Mrs. McGinty points out gratefully). Auxiliary members arrive from all parts of the state, meet their elected government officials, attend workshops conducted by political "pros" and are briefed on current legislative matters by MSMS staff.

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Category I Courses

Michigan Medicine *each month will carry a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of the new Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing will indicate a contact person, so the physician can obtain details. The list will be expanded as courses are developed by accredited sponsors. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.*

The following have been accredited directly by the AMA or by MSMS Commission on Continuing Medical Education:

Organizations:

- Ann Arbor Psychiatric Association
- Michigan Academy of Family Physicians
- Michigan Academy of Plastic Surgery
- Michigan State Medical Society
- Michigan Chapter, American Academy of Pediatrics
- Michigan Dermatological Society
- Michigan Heart Association
- Michigan Lung Association, Lansing
- Michigan Society of Anesthesiologists
- University of Michigan School of Public Health

Hospitals:

- Alma-Gratiot Community Hospitals, Alma
- William Beaumont Hospital, Royal Oak
- Beyer Memorial Hospital, Ypsilanti
- Blodgett Memorial Hospital, Grand Rapids
- Bon Secours Hospital, Grosse Pointe
- Burns Clinic Med.Center, PC/Little Traverse Hospital, Petoskey
- Butterworth Hospital, Grand Rapids
- Central Michigan Community Hospital, Mt. Pleasant
- Community Health Center of Branch County, Coldwater
- Community Hospital Association of Battle Creek
- Detroit-Macomb Hospital Association
- Ferguson-Droste-Ferguson Hospital, Grand Rapids
- Grace Hospital, Detroit
- Henry Ford Hospital, Detroit
- Holy Cross Hospital, Detroit
- Hurley Medical Center, Flint
- Ingham Medical Center, Lansing
- Kalamazoo State Hospital
- Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital), Muskegon
- Marquette General Hospital
- McLaren General Hospital, Flint
- Mercy Hospital, Port Huron
- Mt. Carmel Mercy Hospital & Med. Center, Detroit
- Munson Medical Center, Traverse City
- North Detroit General Hospital, Detroit
- Oakland Medical Center, Pontiac
- Oakwood Hospital, Dearborn
- Pontiac General Hospital, Pontiac
- Port Huron Hospital CME Committee
- Providence Hospital, Saginaw
- Saginaw Cooperative Hospitals Inc., Saginaw
- Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
- St. Francis Hospital, Escanaba
- St. John Hospital, Detroit
- St. Joseph Hospital, Flint
- St. Joseph Mercy Hospital, Pontiac
- St. Joseph Mercy Hospital, Ann Arbor
- St. Lawrence Hospital, Lansing
- St. Mary's Hospital, Grand Rapids
- St. Mary Hospital, Livonia
- Sinai Hospital of Detroit, Detroit
- Edward Sparrow Hospital, Lansing
- Traverse City State Hospital, Traverse City
- V. A. Hospital, Battle Creek
- Wayne County Psychiatric Hospital, Eloise
- West Shore Hospital, Manistee
- Ypsilanti State Hospital, Ypsilanti

Date: July 21-24, "The Psychiatrist and the Public Mental Health System." **Location:** Boyne Mountain Resort, Boyne Falls. **Sponsor:** Michigan Psychiatric Society. **For:** Psychiatrists. **Cost:** MPS Member $70, Non-Member $100, Member-in-Training, $30. **Contact:** Emmanuel R. Casenas, MD, Program Chairman, 32905 W. 12 Mile Road, Farmington, 48024. **Applied for:** 8 hours of Category I Credit.

Date: July 26-28, Summer Meeting. **Location:** Bay Valley Inn, Bay City. **Sponsor:** Michigan Chapter, American Academy of Pediatrics. **For:** Pediatricians. **Cost:** $30 member, $50 nonmember, $10 resident. **Contact:** Miles Tiernan, Executive Secretary, MCAAP, (313) 553-3646. **Approved for:** 7 hours of Category I Credit.

Date: July 28-29, Annual Coller-Penberthy-Thirlby Medical Conference. **Location:** Park Place Motor Inn, Traverse City. **Sponsor:** Munson Medical Center, Traverse City. **For:** All specialties. **Cost:** None. **Contact:** Kenneth H. Musson, MD, Grand Traverse Ophthalmology Clinic, PC, 1105 E. Front St., Traverse City, 49684. **Approved for:** 9 hours of Category I credit.

Date: Aug. 6-10 — Annual Meeting and Scientific Program. **Location:** Sugar Loaf Resort, Cedar. **Sponsor:** Michigan Academy of Family Physicians. **For:** Family Physicians. **Contact:** Rita Feldkamp, MAFP executive secretary, 933 Wing St., Plymouth, 48170. **Approved For:** 28½ hours of Category I credit.

Date: Aug. 13-14, AMA Regional CME Program. **Location:** Northern Michigan University, Don Bottom Conference Center, Marquette. **Sponsor:** American Medical Association. **For:** All specialties. **Cost:** Prices for five courses, $70; Advanced CPR, $160. **Contact:** Gale Jewitt, AMA, (312) 751-6570. **Approved for:** 6 hours of Category I credit, 14 for advanced CPR.

Date: Sept. 1-2 — 1977 Harold C. Mack Symposium on the Physiology and Pathology of Reproduction, "Controversies in Contraception." **Location:** Michigan Inn, Southfield. **Sponsor:** Department of Gynecology and Obstetrics, WSU. **Co-Sponsor:** C. S. Mott Center for Human Growth and Development, Searle Lab. **For:** Gynecologists and Obstetricians. **Cost:** $75. **Contact:** Kamran S. Moghissi, MD, C. S. Mott Center for Human Growth and Development, 275 East Hancock, Detroit 48201. **Approved for:** 14 hours of Category I Credit.

Date: Sept. 16-18 — A Practical Course in Diagnostic Ultrasound. **Location:** Towsley Center, U of M Medical Center, Ann Arbor. **Sponsor:** U. of M Office of Continuing Education, Dept. of PGM/HPE. **Cost:** $125. **Contact:** Floyd C. Pennington, Ph.D., Director, U-M Office of Continuing Education.* **Approved for:** 16 hours of Category I Credit.

(Continued on page 384)

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CATEGORY / *Continued*

Date: Oct. 8, Clinical Day on "Low Back Pain." **Location:** Inservice Classrooms, Holy Cross Hospital, 4777 E. Outer Drive, Detroit. **Sponsor:** Holy Cross Hospital Medical Staff Education Committee. **For:** All specialities. **Cost:** $25. **Contact:** Kenneth K. Newton, M.D., Director of Medical Education, (313) 369-9100, ext. 2355. **Approved for:** 6 hours of Category I Credit.

Date: October 12, Diseases of the Breast. **Location:** St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **Cost:** $50. **Contact:** Department of CME, St. John Hospital, (313) 881-8200, ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 22, "Manifestations of Systemic Diseases in Sub-Specialties." **Location:** Inservice Classrooms, Holy Cross Hospital, 4777 E. Outer Drive, Detroit. **Sponsor:** Holy Cross Hospital Medical Staff Education Committee. **For:** All specialties. **Cost:** $25 for staff members; $35 for non-staff members. **Contact:** Kenneth K. Newton, MD, Director of Medical Education, (313) 369-9100, ext. 2355. **Approved for:** 6 hours of Category I Credit.

Date: November 8-10, MSMS Annual Scientific Session. **Location:** Hyatt Regency Dearborn. **Sponsor:** MSMS Committee on CME Programming. **For:** All specialties. **Contact:** Herbert Auer, MSMS Department of CME Programming. (517) 337-1351.

Date: Nov. 16 — Diseases of the Biliary Tract. **Location:** St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** All specialties. **Contact:** Department of CME, St. John Hospital, Detroit (313) 881-8200, ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 26-30 — Ophthalmology Review. **Location:** Dearborn Inn. **Sponsor:** WSU-Department of Ophthalmology. **For:** Ophthalmologists. **Cost:** $350. **Contact:** WSU Division of CME, Room 1209 Scott Hall, 540 East Canfield, Detroit 48201. **Approved for:** 40 hours of Category I Credit.

Date: Dec. 10 — "Needle Aspirations" Seminar. **Location:** University of Michigan, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** John F. Dunkel, MD, Department of Pathology, Michigan State University, East Lansing 48823 or James W. Landers, MD, Department of Pathology, St. John Hospital, Detroit. **Approved for:** 3 hours of Category I Credit.

Continuing Courses

Date: Continuing Quarterly Journal Club — Surgery; **Location:** Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Surgeons; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital**** **Approved for:** 2 hours of Category I Credit.

Date: Monthly, Cleft Palate Clinic. **Location:** Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital****. **For:** Oral Surgeons, plastic surgeons, pediatricians. **Cost:** None. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 3 hours of Category I Credit.

Date: Monthly, Tissue Audit (Cancer). **Location:** Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Surgeons, ob-gyns, pathology, radiology. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 2 hours per session Category I Credit.

Date: Monthly Lecture Series in Ophthalmology; **Location:** Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Ophthalmogists; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Monthly, Ob/Gyn Journal Club. **Location:** Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** All interested physicians. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Monthly Urology Journal Club; **Location:** Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Urologists; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital****; **Approved for:** 2 hours of Category I Credit.

Date: Begins September, Continuing Training in Family Therapy. **Location:** Suite 1212, North Park Plaza, 17117 W. Nine Mile Road, Southfield. **Sponsor:** Family Institute of Southeastern Michigan. **Co-sponsor:** Ackerman Institute. **For:** Psychotherapists. **Cost:** Varies according to time put in. **Contact:** Carolyn R. Tourkow, MSW, director, Family Institute of Southeastern Michigan. **Approved for:** Hours vary with time spent.

Date: Every Tuesday — Psychiatry — Special Problems Seminar; **Location:** Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Psychiatrists; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital****; **Approved for:** 2 hours of Category I Credit.

Date: Every Tuesday morning, Gynecology/Obstetrics Combined Grand Rounds. **Location:** Jackson Auditorium, Hutzel Hospital. **Sponsor:** Wayne State University Department of Gynecology-Obstetrics. **For:** All interested physicians. **Cost:** No charge. **Contact:** Wayne State University, Division of CME**. **Approved for:** 4 hours each of Category I Credit.

Date: Wednesdays, Sept. 14 - Nov. 16, Cardiology Seminars. **Location:** St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** All specialties. **Cost:** $200. **Contact:** Department of CME, St. John Hospital, (313)881-8200, ext. 321. **Approved For:** 2 hrs per session hours of Category I Credit.

Date: Thursdays, Sept. 15 - Nov.17, Nuclear Medicine in Clinical Practice. **Location:** St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** All Specialties. **Cost:** $200. **Contact:** Department of CME, St. John Hospital, (313)881-8200, ext. 321. **Approved for:** 2 hrs per session hours of Category I Credit.

Date: Each Wednesday, Detroit Medical Center Hand Conference. **Location:** Classroom 3, Second Floor, Webber Wing, Harper Hospital, Detroit. **Sponsor:** Wayne State University. **For:** Surgeons. **Cost:** No charge. **Contact:** Joseph L. Posch, MD, Fourteenth Floor, Kales Building, 76 W. Adams, Detroit 48226. **Approved for:** Hour-for-hour Category I credit.

Date: Second Thursday of each month, Inter-Hospital Pathology Slide Conference. **Location:** St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** Pathologists. **Cost:** No charge. **Contact:** Department of CME, St. John Hospital, 22101 Moross Road, Detroit, 48236, (313) 881-8200. **Approved for:** 3 hrs. each date Category I Credit.

Date: Saturdays — Intermediate Training in Family Therapy. **Location:** Northland Clinic, Southfield. **Sponsor:** The Family Institute of Southeastern Michigan. **Co-Sponsor:** Ackerman Family Institute of New York. **For:** Psychiatrists. **Cost:** $25 per session. **Contact:** Carolyn R. Tourkow, MA, MSW, Suite 1212, North Park Plaza, 17117 West Nine Mile Road, Southfield 48075. **Approved for:** 3½ hours of Category I Credit.

Date: Saturdays, Morbidity and Mortality Conference. **Location:** Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital Department of Surgery. **For:** Surgeons. **Cost:** None. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 2 hours of Category I Credit per session.

Date: Every Saturday, Weekly Conference. **Location:** Gamble Building, Burns Clinic/Little Traverse Hospital, Petoskey. **Sponsor:** Burns Clinic/Little Traverse Hospital. **For:** All interested physicians. **Cost:** None. **Contact:** Ernest W. Carpenter, MD, 560 West Mitchell, Petoskey, 49770.

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*Office of Intramural Education, University of Michigan Medical Center, Dep't. of PGM/HPE, Ann Arbor, 48109

**WSU Division of CME, Room 1209, Scott Hall, 540 E. Canfield, Detroit, 48201 (313) 577-1453

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902

****Department of CME, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 272-6000

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Meetings

(See also listing of Category I programs on page 382)

July 10-13 – "A Sub-System Within the Health Care Delivery System," sponsored by Continuing Education, School of Public Health, University of Michigan, contact: Anna B. Brown, PhD, Director of Continuing Education, 3550 School of Public Health I, the University of Michigan, 109 S. Observatory Street, Ann Arbor, 48109.

July 11-22 – Biology of Aging, Ann Arbor, contact: Dorothy H. Coons, Director of Cont. Ed., The Institute of Gerontology, The University of Michigan-Wayne State University, 520 East Liberty, Ann Arbor, 48109.

July 18-21 – Medical Office Management Institutes (MOMI), sponsored by Conomikes Associates, Inc., Hospitality Motor Inn, Lansing, contact: Conomikes Associates, Inc., 4270 Promenade Way, Suite 122, Marina del Rey, CA, 213/823-4661 or call TOLL FREE 800/421-6512.

July 22-24 – MSMS Council, Deer Lake, Boyne Falls, Michigan, contact: Warren Tryloff, MSMS Director.

July 24-29 – "Supervision in the Health Field: Theory, Process, Practice," sponsored by Continuing Education, School of Public Health, University of Michigan, contact: Anna B. Brown, PhD, Director of Continuing Education, 3550 School of Public Health I, the University of Michigan, 109 S. Observatory Street, Ann Arbor, 48109.

August 6-10 – Annual Convention and Scientific Assembly, Michigan Academy of Family Physicians, Sugar Loaf Mountain, contact: Rita Feldkamp, Executive Secretary, MAFP, 933 Wing St., Plymouth, 48170.

August 7-12 – "Problems in Planning and Evaluation," sponsored by Continuing Education, School of Public Health, University of Michigan, contact: Anna B. Brown, PhD, Director of Continuing Education, 3550 School of Public Health I, the University of Michigan, 109 W. Observatory Street, Ann Arbor, 48109.

September 5 – MSMS/INTRAV Around-the-World Adventure, contact: Marce Ireland, MSMS headquarters.

September 7 – MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS Director.

September 12 – MSMS/INTRAV Orient Adventure, contact: Marce Ireland, MSMS headquarters.

September 17 – Michigan Society of Pathologists September Seminar, "Renal Disease," St. John Hospital, Detroit, Michigan, contact: John F. Dunkel, M.D., Department of Pathology, MSU, East Lansing, 48823.

September 23-24 – Reunion, Medical Center (all classes), 5-year Classes (1927-1972) Medical and Nursing, University of Michigan, contact: Alumni Association Office, 313/764-0384.

September 29-30 & Oct. 1 – "Implant Surgery for Joints and Tendons in the Hand," sponsored by American Society for Surgery of the Hand, Blodgett Memorial Medical Center, Grand Rapids, contact: Blodgett Memorial Hosp.

October 10-11 – First Ann Arbor Symposium on Biology of Special Senses in Aging, Institute of Gerontology, the University of Michigan-Wayne State University, contact: Dorothy H. Coons, Symposium, Institute of Gerontology, University of Michigan, 520 E. Liberty, Ann Arbor, 48109.

November 2 – MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS Director.

November 8-10 – MSMS Annual Scientific Meeting, Dearborn Hyatt Regency, Dearborn, contact: Herb Auer, MSMS headquarters.

December 14 – MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS Director.

MSMS insurance premium increases half state average

Physicians who join MSMS reap a number of benefits from their membership. Among the most recent is the announcement that MSMS Blue Cross/Blue Shield group insurance members will incur a rise in premium rates less than half that of the average statewide increase for the Blues' programs.

MSMS members' premiums for the coming year will rise 12% to 17%, while statewide, the Blues' premiums will rise 28.3%. MSMS programs have a smaller premium increase because of lower utilization in 1976, according to Wayne Burmeister, manager, MSMS Member Services Department.

The figures break down as follows:

Group No.	Group Covered	No. Enrolled	% increase in premium
94000	Physicians and families (MVF-2)	4,266	12.8%
94180	Physicians and families (BC only)	353	17.0%
94211	MD's widows	220	13.0%
94213	Physicians and families (BC/BS Econoplan)	481	14.5%

In Memoriam

Lloyd K. Babcock, MD
Birmingham

Lloyd K. Babcock, MD, 84, of Birmingham, died May 25. A Detroit resident most of his life, Doctor Babcock practiced there until retiring 11 years ago. Doctor Babcock was an organizer and charter member of the Wayne County Board of Health and served as county coroner from 1946 to 1948. A graduate of the Hahneman Medical School in Chicago, he was on the staff of New Grace Hospital, Detroit.

Walter L. Barron, MD
Ann Arbor

Walter L. Barron, MD, 47, of Ann Arbor, died April 27. He was a staff member at St. Joseph Mercy Hospital since 1963. A graduate of the University of Michigan Medical School, Doctor Barron had served as U-M clinical instructor in internal medicine. Doctor Barron was a member of the American College of Chest Physicians and other medical organizations.

Guy R. Bullen, MD
Jackson

Jackson public school physician for 24 years, Guy R. Bullen, MD, died May 3 at the age of 81. Doctor Bullen was in private practice until 1974. He was graduated from the University of Michigan Medical School. He was past president of the Jackson County Medical Society, and served 30 years as a director of the Jackson County Tuberculosis and Respiratory Disease Association. Doctor Bullen received the MSMS 50 year award.

Donald M. Harris, MD
Battle Creek

Donald M. Harris, MD, 66, of Battle Creek, died May 4. A mental health consultant, Doctor Harris was a former director of the Calhoun-Branch Community Mental Health Services Board and health director for Branch and Hillsdale counties. Doctor Harris received his medical degree from the University of Nebraska, where he also received a master's degree. He also received a master's degree in public medicine from the World War II and was a public health consultant in Germany for the U.S. Department of State. He was public health officer for the Nebraska and Iowa state health departments before serving in Michigan.

Earl E. Kleinschmidt, MD
Ann Arbor

Earl E. Kleinschmidt, MD, Ann Arbor internist, died April 23 at the age of 73. A graduate of the University of Michigan Medical School, Doctor Kleinschmidt was associate professor and chairman, Department of Preventative Medicine, Public Health and Bacteriology at Loyola University School of Medicine. In 1942 he became Ohio Health Commissioner and Director of School Health, and then in 1944 he became associate national director of the American Red Cross. Doctor Kleinschmidt was past President of the American School Health Association, and a member of the National Board of Medical Examiners, American Public Health Association, American Association of Medical History, International Society of Medical Health Officers and the American Trudeau Society.

Arthur B. Levant, MD
Detroit

Arthur B. Levant, MD, formerly of Detroit, died at the age of 66. A graduate of the University of Minnesota, Doctor Levant was on the staff of Hutzel Hospital in Detroit for 34 years.

Chester A. E. Lund, MD
Battle Creek

Chester A. E. Lund, MD, 78, Battle Creek, died May 6. A graduate of the University of Minnesota, Doctor Lund served as medical director of the Calhoun County Health Department for many years. Doctor Lund was a former chairman of the administrative division of the Michigan Public Health Association and chairman of the school health committee of the Michigan Health Officers Association. He was honored by the Battle Creek Area Council to Help Hire the Handicapped; the Michigan Health Officers Association and the Michigan State Department of Health for his efforts in public health.

Richard C. Sargent, MD
Marysville

Richard C. Sargent, MD, Detroit obstetrician/gynecologist, died May 17 at the age of 56. Doctor Sargent, of Marysville, was an industrial physician with the Ford Motor Co. for many years and also served as a physician consultant to the Michigan Bell Telephone Co. He was a fellow of the American Association of Obstetrics-Gynecology, and a member of the Michigan Industrial Medical Society. Doctor Sargent was a graduate of Wayne State University Medical School.

Classified

DIRECTOR OF MEDICAL EDUCATION — Seeking a board certified or board eligible physician, preferably in a primary care discipline and with teaching experience, for a recently formed educational corporation with three hospital members, totaling approximately 520 beds. Excellent salary and benefits. Position available immediately. Please send curriculum vitae, or call A. M. Moeller, MD, President, Bay County Medical Education, 100 Fifteenth Street, Bay City, Michigan 48706, 517/893-5271.

FOR SALE a relatively new, nice medical building, fully equipped for medical practice. Down payment is very reasonable and sale would be by land contract. The Doctor who has had excellent practice for 17 years retired due to poor health. If interested call 1-517-592-2124 or 1-517-592-5165.

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OB-GYNE — WE ARE SEEKING a board certified or eligible physician to replace an OB partner lost because of health reasons. We are a 20-physician, multi-specialty group located 55 miles northwest of Chicago in the Chain-O-Lakes resort area with easy access to the city. Our candidate will step into an active three-man practice with incentive pay from day one (with a guaranteed minimum draw), malpractice paid, excellent fringe benefits. Our group is physically adjacent to a 144-bed general community hospital and state trauma center. Call or write Jim Dickson, McHenry Medical Group, 1110 North Green Street, McHenry, Ill 60050 — 815/385-1050.

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POSITIONS AVAILABLE. For the Lansing office, two Internists and one Psychiatrist — For Traverse City, a part time or full time Internist — and for Oak Park, one Internist and possibly one Psychiatrist, — These physicians to be with the Disability Determination Program under Social Security Administration. Salary currently in high thirty thousands, plus 22% fringe benefits, including life, accident, long term disability and hospital and major medical coverage. An outstanding benefit is deferred compensation. Pension benefit after 10 years' service. Liability insurance not necessary. 40 hour work week. No weekends or nights. 50 hours allowed for obtaining necessary CME credits. Vacation leave and sick leave is given. Position entails review of medical records, training and teaching of disability examiners, as well as some public relations. An equal opportunity employer. All enquiries treated confidentially. For further details, please write: Disability Determination Program, Box 30011, Lansing, Michigan 48909, OR call collect: Harry D. Nesmith, M.D., Chief Review Physician, (517) 373-7789.

EXCELLENT OPPORTUNITY for doctor to build his own practice while enjoying benefits from established practice. Present work week 32 hours, no weekends, no hours outside office. Twelve years same location, this practice is about 80% bariatrics, 20% general medicine. Great potential for developing large family practice. Salary for two years, then full partnership or option to take over entire practice. $60,000 first year with vacation and bonus. Opening available now. Send resume to H. B. Cowis, Office Manager, 112 S. Ridgeview Drive, Indianapolis, Indiana 46219.

FAMILY PRACTICE RESIDENCY PROGRAM DIRECTORY: A 500-bed, church-operated, suburban community hospital in Michigan is searching for a full-time director of its new Family Practice Residency Program. This fully-accredited hospital has an excellent educational atmosphere with six AMA-approved residency programs. Representative duties of the position include the construction, maintenance, and periodic revision of the Resident Training Program for Family Practice; selection, organization and scheduling, and continuing direction of the Resident Staff in Family Practice. Also included is the assignment and supervision of teaching functions of the Attending Staff, the development of conference content, speaker programs, and other formal educational activities. The applicant sought should be certified or Board eligible by the American Board of Family Practice Residency. In addition, the applicant should possess good teaching abilities and preferably a background of practical experience in the practice of medicine. Salary is negotiable. Reply to Michigan State Medical Society, 120 W. Saginaw, Box 4, East Lansing, MI 48823.

ATTRACTIVE OFFICE SPACES now available for rent in the Muskegon Mall area. Located in the Medical Arts Plaza, 315 West Clay Avenue, Muskegon, Michigan. Reasonable rates with many modern conveniences. For further information please contact Mrs. Westerman, (616) 726-3641 or after 5:00 p.m. (616) 725-7120.

PAW PAW AREA — Need for anesthesiologist, orthopedic surgeon and general practitioner. Modern well-equipped, fully accredited general hospital located in Paw Paw serves growing area in SW Michigan close to Kalamazoo. Office space and equipment available. Excellent recreational and cultural area in the heart of Michigan's Grape & Wine Country. Good schools, all denominations of churches. A fine place to live. Contact: Michael H. Payne, Administrator, Lake View Community Hospital, P.O. Box 209, Paw Paw, MI 49079. Phone: (616) 657-3141.

WANTED: Staff physician, Michigan license required, for 350-bed fully accredited hospital for the care of rehabilitation, tuberculosis, psychiatric and chronic disease patients. 40 hours week. Excellent salary and fringe benefits. Contact: Personnel Director, Saginaw Community Hospital, 3340 Hospital Road, Saginaw, Michigan 48605.

PEDIATRICIAN — BOARD CERTIFIED: Solo practitioner desires associate for practice in Southeastern Michigan near Downriver Area. Terms negotiable. Send replies to MSMS, 120 W. Saginaw, Box 3, East Lansing, MI 48823.

PHYSICIANS ASSISTANT — Graduates from Western Michigan University August 1977 with B.S. degree in medicine, AMA approved. Seeks small group or solo practitioner that could utilize a P.A. B.S. University of Wisconsin, four years experienced corpsman in the U.S.N. Write or call Donald Faulkner, 1605 W. North Street, Kalamazoo, MI, 49007, 616/349-2705.

31-YEAR-OLD PHYSICIAN ASSISTANT seeking general practice position in small, remote community. Seven-year university bio-science background, graduate 24-month Physician Assistant Program, currently independent duty in Alaska providing general medical care for a community of 1,300 people. Daniel Muniak, Box 272, Metlakatla, Alaska 99926. 907/882-3771.

PRACTICE FOR SALE in a small town 20 minutes drive from University of Michigan Medical Center Family Practice, same location for over 40 years. Good gross income with minimal rent and low overhead. Office fully equipped with furniture, X-ray, lab, minor surgery set up, cautery and EKG. Call 313/761-2289 or write to A. Abraham, 1960 Traver Knoll, #208, Ann Arbor, Michigan 48105.

EXCELLENT OPPORTUNITY FOR PRACTICE in the small community of Mason south of Michigan State University. 1000 feet of new office space is available with Mason General Hospital within 100 yards. Building is ranch-type, landscaped, with large, paved parking lot. Write Dr. Douglas Gray, 230 S. Temple Street, Mason, Michigan 48854.

FAMILY PRACTICE/GENERAL PRACTICE: If you want to step into an existing solo, possible partnership, practice netting approximately $75,000 per year with no capital investment, in Michigan's Upper Peninsula, please contact Michael Drobot, Administrator, Menominee County Lloyd Hospital, 1110 Tenth Ave., Menominee, Michigan 49858. Phone 906/863-5571.

ORTHOPEDIC SURGEON: Board Certified or eligible, name your terms and guarantee. Northern Michigan resort area of 60,000 population. Contact D. L. Patterson, 2225 E. Randol Mill Road, Suite 321, Arlington, Texas 76011, phone 817/227-6437.

FULL-TIME ASSOCIATE DIRECTOR — Position of Assistant or Associate Director available to fill 3rd full-time faculty position in well established 9-year-old Family Practice Residency program in Mid-Michigan.

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Strong point of this community based program is its excellent community involvement of Family Physicians and traditional specialists dedicated to a teaching program. Soon moving to all new ambulatory care center.

Should be Board Certified. Full complement of 24 residents. Duties would be resident and 3rd and 4th year medical students teaching and supervision. Minimal administrative duties.

Michigan is a water wonderland with all winter and summer sports readily available. 150 miles to best skiing in the midwest.

Contact: Robert J. Toteff, MD, Director, Family Practice Residency, 705 Cooper Street, Saginaw, Michigan 48602.

AMA aiding MDs seeking to buy computers

A new on-site consultative service is offered by the AMA for physician groups involved in or considering the use of computers in their practices. The AMA's Consultative Services Program has answered over 1,500 inquiries from physicians since its inception in January.

The program helps physicians know when computer-based services are justified, what kinds of services are suitable now and what impact growth and technological advances will have, and how those services are most efficiently implemented.

Further information is available from Daniel K. Harris, Department of Computer Systems in Medicine, Division of Medical Practice, AMA, 535 N. Dearborn, Chicago, 60610.

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Potpourri

By Herbert A. Auer, Executive Editor

"The dues physicians are asked to pay to the AMA to keep it effective are small compared to what members of organized labor pay their unions. But so many of us complain and refuse to pay it. We are taken in by propaganda which is aimed to destroy the AMA, which is our only voice in Congress," wrote MSMS Councilor Carl Gagliardi, MD, in a recent issue of the *Detroit Medical News*.

* * *

What's a fair profit? Even though most Americans think industry earns far more that it really does, poll respondents believe that a quarter on a dollar would be fair — or about five times the nickel the average manufacturer really makes. Clearly, the public's heart is bigger than economic reality. Few companies of any kind come close to that quarter, yet half the public still believes that businesses in general — and oil companies in particular — make excessive profits.

* * *

In 1964 the Surgeon General reported that 52.4 percent of all males over 21 smoked; by 1975 this percent had dropped to 39.3. Physicians as a group have reduced their smoking more than any other.

* * *

Speaking of physical fitness, who wastes more energy than the earnest jogger? He runs to nowhere, and all his spent effort is lost to society. But put millions of joggers on treadmills and you will generate enough electricity to light up Toledo.

* * *

Open letter to James J. Lightbody, MD, MSMS past-president:

> Don't get discouraged as you continue your efforts to encourage physicians and others to purchase a copy of *Rant and Rave*.
>
> You may recall the problems Edward Fitzgerald had with his book, *Omar Khayyam*. He was unable to interest any British publisher in printing it, and finally printed it at his own expense in pamphlet form. For awhile it was offered to the public for a shilling, but still it did not sell, so the price was reduced to a penny.

An example of things to come with the inevitable increasing involvement of the Federal government in medicine is the cost of processing Medicare claims. A government study reports that it costs Social Security $12.39 to process every Medicare claim, but private carriers can do the same job for only $6.45. Each government worker processes 2,500 claims per year vs. 3,900 to 6,600 for private carrier employees who are paid a great deal less than the inflated bureaucrat wages in Washington.

* * *

Editor Frank Cole, MD, of Nebraska Medical Journal writes, "Idle conversaton is idle and generally does not improve on silence. At its best, it is the product of two of us telling each other how good we are, and how right we are, and all about ourselves."

* * *

The use of marijuana among high school seniors increased some in 1976 over 1975, according to a U-M nationwide survey. The proportion who reported ever using marijuana rose from 48 percent to 53 percent, according to U-M *Michigan Alumnus* article.

* * *

"Today, it is popular to be anti-medicine," MSMS Council Chairman Ernest P. Griffin, Jr., MD, told the MSMS House of Delegates in his annual message. He continued, "Numerous nefarious schemes are being promulgated in an attempt to control the practice of medicine. We are well aware that governmental interference in the practice of medicine does not decrease costs but does definitely cause deterioration in the quality of medical care."

* * *

Hats off to the Family Practice Club movement of the Michigan Academy of Family Physicians. This program began in 1969, when MAFP was the third state academy to launch such clubs. Rodman Jacobi, MD, MSU, is the coordinator now for the lively clubs at the three medical schools.

* * *

Outside of Pittsburgh, you will see a sign: "Neville Township reminds you . . . 30 days hath September, April, June and November, and anyone exceeding our speed limit."

Michigan Medicine Contents

***Michigan Medicine*, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about contemporary issues and actions of the Michigan State Medical Society, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.**

Special articles

396 Legislature agrees to raise Medicaid screens to parity with Medicare; Thomas R. Berglund, MD

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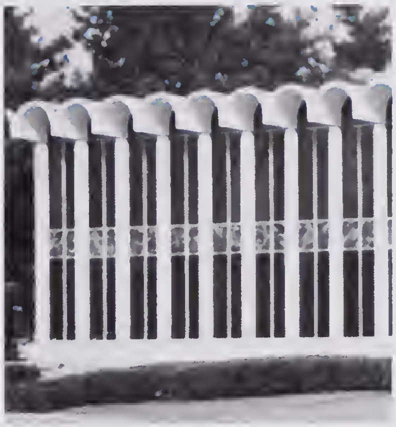

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In the next issue . . .

First details of the MSMS Scientific Meeting, Nov. 8-10, Hyatt Regency Dearborn.

Vernon V. Bass, MD
MSMS President

How our MSMS operates

Our many-sided MSMS is strong, vital and well-organized. It is limited only by our own vision, talents and dedication.

As with the AMA, MSMS policy is set by the House of Delegates, which meets once a year to act on resolutions submitted by members of county medical societies. The delegates elect their speaker and vice speaker — currently James D. Fryfogle, MD, Detroit, and David Siegel, MD, Lansing, respectively.

Throughout the year, MSMS policy is carried out by the 27-member MSMS Council, or board of directors. Councilors are elected by MSMS delegates to represent geographical districts of the state. The Councilors elect their chairman and vice chairman — currently Ernest P. Griffin, Jr., MD, Flint, and Louis R. Zako, MD, Dearborn Heights.

A 30-member staff at MSMS headquarters in East Lansing ably assists MSMS members and leaders. Led by Warren Tryloff, director since 1970, they serve through five departments.

CME Programming and Communications, Herbert A. Auer, manager, seeks to develop and present MSMS Category I programs; and to tell the public the doctors' side of medical issues through the use of various media.

Delivery of Quality Medical Care, Richard Campau, manager, deals with peer review systems, health care delivery, CME accreditation, health manpower and hospital relations.

The Bureau of Economics, John H. Anthony, manager, provides socio-economic data, presents indepth practice management seminars, and includes the new sub-department of Negotiations.

Government Relations, Bruce Ambrose, manager, works on the issues of professional liability and arbitration, lobbies for medical legislation, and represents MDs before government agencies.

Member Services, Wayne Burmeister, manager, oversees all MSMS meetings, handles member records and benefit programs.

In addition, MSMS staff manage the Doctor-of-the-Week program, assist MDPAC, provide staff for specialty organizations, medical assistants and auxiliary members and provide legal opinions. MSMS works with components, started and now monitors the Michigan Physicians Mutual Liability Company and places medical students in community hospitals for summer externships.

When impotence due to androgenic deficiency is driving them apart

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Methyltestosterone U.S.P. – 5, 10, 25 mg.

New Double-Blind Study ANDROID-25 *vs.* Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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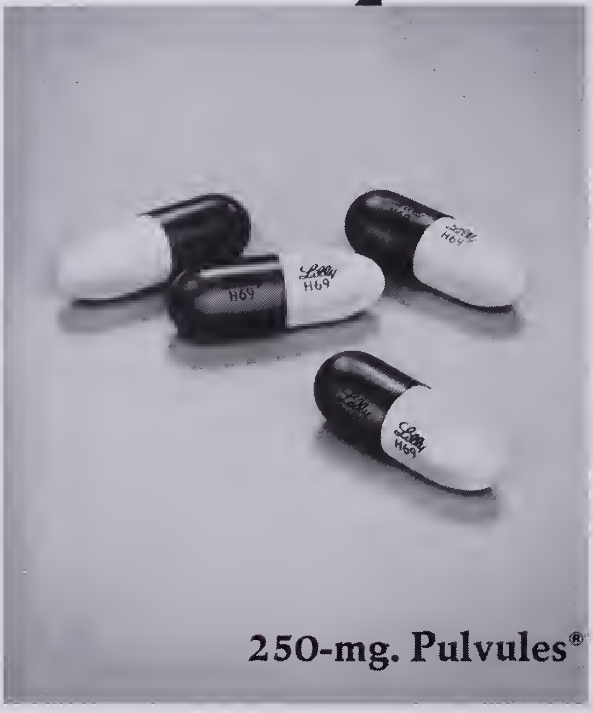

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Major MSMS goals are set; now let's achieve them!

By Ernest P. Griffin, Jr., MD
MSMS Council Chairman

I personally appeal to all MSMS members to participate in moving along the 11 programs of work adopted by the MSMS Council for 1977-78.

These major thrusts include projects selected by the House of Delegates and ongoing activites of MSMS committees and the Council. Some of the programs are new and others are being carried over.

The future of the medical society revolves around greater involvement by our members — and in trying to convince every licensed physician to be an active member of his component society and MSMS, and hopefully the AMA too.

The only way I can see us being able to have input into the health care system and to prevent further federal and state intrusions is for every doctor to join together for unity.

The 11 programs of work were reported in a recent issue of *Medigram* but are listed again below:

- To continue efforts to make arbitration work.
- To continue development of a new department of negotiations.
- To continue efforts to find solutions to professional liability programs.
- To continue to provide quality continuing medical education programs at reasonable cost.
- To continue legislative activities to accomplish MSMS goals.
- To review and prepare for countersuits in professional liability suits.
- To aggressively recruit and retain members.
- To actively expand liaison with the leadership of specialty societies.
- To begin to implement new guidelines adopted so MSMS can evaluate service benefit medical payment programs.
- To develop and conduct educational programs about the cost of medical care.
- To implement restructuring of MSMS committee activities.

The Council will guide and direct the work of its committees and task forces and the MSMS staff to accomplish these goals. The work of these groups will be reported to all MSMS members in *Medigram* so that interested members can send in ideas, can voice their opinions in our good publications, and personally can support these efforts for the public and for physicians.

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Medicaid ambulatory payments to increase to current Medicare levels October 1

By Thomas R. Berglund, MD, Chairman
MSMS Committee on State Legislation and Regulations

Medicare screens will determine payment to physicians providing ambulatory services to Medicaid patients beginning Oct. 1.

The Department of Social Services budget appropriated by the Legislature in the final day of its spring session explicitly establishes current Medicare fee screens for ambulatory medical services effective Oct. 1, and bumps the physician services line item by $18 million to meet the fee increase.

The language in the appropriations bill was the key MSMS objective in its Medicaid legislative package. MSMS sought full Medicare screens both in its Medicaid Liaison Committee functions and the legislative arena. Payments have been frozen at 1973 screens, which were based on 1972 charge data. All discounting — a frequent procedure during hard times for the state in the past — will be discontinued under the new appropriation, also.

The Legislature went home with three important items of MSMS legislation half-way through the process, and action on them likely in the autumn.

Major action

House Bill 4936, a bill to change *continuing medical education* requirements from 50 hours a year to 150 hours in three years, passed the House and went to the Senate committee on State Affairs. The bill will not affect 1977 CME criteria — 50 hours will be necessary to re-register for 1978. But if the Senate approves the legislation in the fall, all CME acquired in the past three-year cycle will be applicable; in other words, if a physician earns more than 50 hours in 1977 the excess will be applicable when re-registration for 1979 comes due with its 150-hour requirement. A House amendment to the bill would require that 10 of the 150 hours be in the general area of medical ethics.

House Bill 4515 was reported with recommendation to pass by the House Judiciary Committee and will be on the floor agenda when the House returns Sept. 13. The bill defines *malpractice* for all professions It would establish in statute what is currently case law — community standards for general practice and national standards for specialty practice. However, it provides that facilities available are a factor in determining whether national standards can be applied in specialty practice.

The long-debated proposed *Public Health Code* finally passed the House after extensive amendments. The bill was held back for several weeks while dentists and dental hygienists argued over hygienist representation on the dental practice board. Chiropractic scope of practice, despite several attempts to liberalize it, held to the Public Health Committee recommendation supported by MSMS, including specific proscription against invasive procedures, incisive surgery and prescriptions. The bill has been referred to the Senate Health & Social Services Committee, which plans public hearings before the fall session.

A long-standing attitude of MSMS is incorporated in HB 4425, which would enable local school districts to provide *sex education* in their health education curricula. This bill, while it would loosen the strings on sex education, would establish quality criteria for health educators and specifically prohibit teaching abortion as a birth control method. Parents would be able to withhold children from the classes if they desire. The bill passed the House and went to the Senate committee on education.

A bill to require physicians to search radiation records and notify patients, their parents or guardians, of danger connected with *head and neck radiation* in the past remained in the Senate Health and Social Services Committee while a means of alerting persons to potential danger is sought. SB 347 would place the responsibility for search and notification upon physicians. Conversations on achieving the goal without legislation will take place during the summer recess.

Of high interest to MSMS this year was passage of legislation to extend the *Brown-McNeely* medical malpractice fund, which would have terminated June 30 without new legislation. MSMS and the Insurance Bureau worked together closely to develop language to provide for effective phasing out of the fund in the next two years. The new act, passed and signed by the Governor, provides a two-year extension, and the creation of a stabilization reserve fund to forestall the possibility of an assessment against all physicians. Most testimony during the legislative process on the new legislation indicated that Brown-McNeely can and ought to be merged into the private insurance market.

Several bills were introduced in May and June to legalize *Laetrile* for cancer therapy in Michigan. The bills vary from permitting manufacture and prescription in Michigan to preventing licensing boards from disciplining physicians, hospitals or pharmacists who make Laetrile available to patients. The campaign to gain state sanction of Laetrile is fraught with emotion and little else. Ten states have legalized Laetrile, including neighboring Indiana; five states have rejected such legislation. The battle over Laetrile may be a major issue in the fall session.

Other legislation

Other legislative activity of medical interest this spring includes:

•HB 4110 (also SB 683), to appropriate funds to Michigan Medical Schools to start "Fifth Pathway" programs to return American students in foreign medical schools to Michigan. *No action – Consideration likely in the fall.*

•HBs 4135-36, to establish one-day, one-trial jury selection in Michigan courts with no exemptions. Doctors could be called for jury duty. Provision is made for deferments in extreme circumstances. *Passed by House; to Senate Judiciary Committee.*

•HB 4215, to set $500,000 ceiling on medical malpractice verdicts and establish life awards. *No action.*

•HB 4263, to provide that plaintiff in professional liability case who loses by dismissal or jury verdict must reimburse defendant for actual costs. *No action.*

•HB 4340, to remove requirement in 1976 Medical Practice Act legislation that two members of the Board must attend all disciplinary hearings but cannot sit in final Board deliberations of the case. *Passed and signed by Governor.*

•HB 4491, to require Health Systems Agencies to identify excess hospital beds and recommend plan to eliminate same. Under intense discussion. *No formal action – Definite action certain in fall.*

•HB 4549, to provide flexibility to Medical Practice Board in considering physicians who fail to meet continuing medical education requirements. *No action.*

•HB 4918, to remand all malpractice suits claiming damages of less than $10,000 to binding arbitration. *No action.*

•HB 4919, to provide that Insurance Commissioner shall promulgate rules establishing limits on malpractice recovery. *No action.*

•HB 4920, to require that neither physician nor insurer disclose amount of liability insurance coverage until verdict is rendered. *Passed by House: to Senate Judiciary Committee.*

•SB 15, one of several bills to delicense health care professionals (SB 15-physicians) upon conviction of Medicaid fraud, but not until final appeal is concluded. *Passed and signed by Governor.*

•SB 124, to extend all arbitration agreements for one year after execution. *No action.*

Recent MSMS "doctor of the week" Robert E. Paxton, MD, Fremont, left, and Mrs. Paxton lunched during their week in Lansing with Lt. Gov. James Dammon. The popular and successful "doctor of the week" program is in its seventh year.

MSMS Scientific Meeting

Q&A

Dates — Nov. 8, 9, 10, 1977
Hyatt Regency Dearborn

This article is an interview between Michigan Medicine *and Robert F. Wilson, MD, Detroit, program chairman for the 1977 MSMS Annual Scientific Meeting, November 8-9-10 at the Dearborn Hyatt Regency. Doctor Wilson, a professor of surgery at the Wayne State University School of Medicine, was program chairman for the very successful 1976 meeting. Here are his answers to some questions about the meeting . . .*

QUESTION: How are plans coming for the 1977 Annual Scientific Meeting?

DOCTOR WILSON: Plans are moving well. We hope to be able to send detailed information to physicians concerning the program in August and accept advance registrations as early as September. We held a major planning meeting in June with representatives of the specialty societies and sections; and the attendance at this planning meeting was twice as large as in 1976.

* * *

QUESTION: What is the theme for the 1977 project?

DOCTOR WILSON: The overall theme this fall will be "Practical Advances in Patient Management." The emphasis will be on the practical aspects of everyday patient care. We will limit discussion of rare or exotic subjects, and focus on medical care problems that occur frequently. Whenever possible, the half-day courses also will deal with basic science information appropriate to the content to help the physician understand newer diagnostic and therapeutic measures.

* * *

QUESTION: What's your personal hope for the fall meeting?

DOCTOR WILSON: We were very fortunate last year. We originally planned to offer 20 courses for 800 physicians — and ended by offering 48 courses which 2,000 physicians attended. This fall, we again will shoot for 2,000 doctors or more — and we will offer them an even better program. As program chairman, I am stressing quality in our program more than anything else. We want to have the world's best CME meeting right here in Michigan for Michigan doctors. I want a meeting that all of us can be proud of.

* * *

QUESTION: How will the three-day meeting be organized?

DOCTOR WILSON: We changed some old patterns last year to offer half-day Category I courses. This year we will build upon that basic program and again offer half-day, three-hour courses in a wide variety of topics to help the doctor in practice.

* * *

QUESTION: Who will organize the courses?

DOCTOR WILSON: We have asked the specialty societies and the MSMS sections to again suggest topics for courses based on the needs in each of their specialty areas. We also have asked department heads at the three medical schools to make recommendations and to volunteer their expertise. Knowledgeable physicians will be appointed as course directors to obtain the speakers and help with the many details of running a half-day program.

* * *

QUESTION: What will be new this fall?

DOCTOR WILSON: We hope to be able to offer to physicians at the meeting, free of charge, blood tests and EKG examinations. We are working

Doctor Wilson

out those details now. It is my personal belief that some physicians are not anxious to have blood tests and EKGs done in their hospitals because the results may not really be confidential. We hope to make this service available to those who are interested.

* * *

QUESTION: Why hold the meeting again at the Hyatt Regency in Dearborn?

DOCTOR WILSON: This hotel has plenty of room and is handy for physicians driving in. Last year, we had as many as 11 half-day courses running at the same time. Furthermore, many spouses enjoy the stay because of the excellent shopping center connected to the hotel with the unique monorail.

* * *

QUESTION: How many out-of-state speakers will you have?

DOCTOR WILSON: Funds are being allocated so each course director may spotlight at least one out-of-state speaker. We hope the best possible expert will be invited to our Michigan program in each of the courses. Let me stress that there are many Michigan physicians who are extremely well-qualified to serve as course instructors. However, although the out-of-state speaker may not know more than a Michigan authority, the doctors in the class might listen better.

* * *

QUESTION: Frankly, I object to pre and post tests at meetings like this. Will I have to take tests and turn in answers, etc.?

DOCTOR WILSON: We will encourage the course directors to develop some pre- and post-test questions to be used only on a voluntary basis. We will not collect the papers nor record any grades. However, the questions can help each of us individually gauge our knowledge in that particular area. These questions can also serve as a focus for discussion.

* * *

QUESTION: How does MSMS decide what to charge for the courses, etc.?

DOCTOR WILSON: The 1977 MSMS House of Delegates approved the practice of the MSMS Council to charge physicians who attend courses fees sufficient to cover expenditures for honorarium, speakers' travel costs, rental of facilities, audio-visual needs, printed programs, mailings, coffee breaks, etc. All the MSMS staff costs are covered by the MSMS Council out of the dues income. In 1976 the tuition for members was $5 per credit hour and there was a surplus of cash income over out-of-pocket expenditures. It is estimated that if the same number of physicians participate this fall, $3 per credit hour will be sufficient. A charge of $9 for a three-hour, half-day course is extremely low, and possible only because the Michigan physicians acting as instructors and course directors are not reimbursed and because MSMS assumes an estimated $42,000 in staff salaries.

* * *

QUESTION: I understand that MSMS does not pay Michigan speakers. Why?

DOCTOR WILSON: MSMS has had a policy for many years that Michigan physicians invited to speak at the Annual Scientific Meeting do not receive honoraria. We believe that is a privilege and obligation for Michigan physicians to share their knowledge without charge with other doctors in their own state at the major MSMS meeting.

State's med schools to share funds to coordinate courses

Michigan's four medical schools have received $57,898 to plan and develop a network for sharing their educational resources.

The two-year grant from the National Fund for Medical Education was made to the Michigan Medical Schools Council of Deans, representing the four medical schools.

Their consortium network to share educational resources will be designed to improve course development and evaluation, to eliminate duplication, and to help reduce costs of medical education, according to the project's director, J. Thomas Parmeter, MD. He heads Michigan State University's office of curriculum implementation and is associate professor of medical education, research and development.

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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(Continued on page 402)

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asodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

U S Pat No 3,056,836

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Roerig presents a guide through the labyrinth of vertigo

CURRENT CONCEPTS IN THE DIAGNOSIS OF VERTIGO
TREATMENT OF VERTIGO
VERTIGO HISTORY FORMS
VERTIGO
CURRENT CONCEPTS IN THE DIAGNOSIS AND TREATMENT OF VERTIGO
Presented as a service to the medical profession by
ROERIG

Vertigo is a potentially complex condition often encountered in office practice. Over 3.5 million patient visits last year were traceable to conditions of the inner ear, with vertigo or dizziness as prominent symptoms.

Roerig can help keep you informed on the latest in vertigo therapy through complimentary materials designed to aid in diagnosis, treatment and patient education.

- **Current Concepts in the Diagnosis and Treatment of Vertigo**—This two-volume audio cassette/print compendium presents the views of four leading clinicians. Subjects include: history-taking, etiology, symptomatology, diagnostic techniques and treatment.
- **Anatomy Made Simple**—Explanation of the cause and treatment of vertigo can be aided by a detailed anatomic representation of the inner ear structures.
- **Continuing Update on Vertigo Therapy**—The most recent research and clinical concepts are presented in a semi-annual publication, *Journal of Vertigo*. Contents include an original article and abstracts from the international biomedical literature.
- **Accurate Patient History-Taking**—A specially designed patient questionnaire can aid in determining the nature of your patients' symptomatology. The *Vertigo History Form* can also provide important diagnostic clues to possible etiologic factors.

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☐ Please send me complimentary materials on vertigo therapy.

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City__________ __________ State__________

Zip__________ Specialty__________

Here are recent Michigan medical statistics

Approved Residency Positions In Michigan

Positions offered 1974-75

	First Year	All Years
Anesthesiology	20	64
Colon and Rectal Surgery	4	4
Dermatology	14	44
Family Practice	38	106
General Practice	6	12
Internal Medicine	181	450
Neurological Surgery	4	17
Neurology	12	36
Obstetrics-Gynecology	58	216
Ophthalmology	14	44
Orthopedic Surgery	27	103
Otolaryngology	10	34
Pathology	46	154
Pediatrics	65	159
Pediatric Allergy	1	2
Pediatric Cardiology	2	4
Physical Medicine and Rehabilitation	7	21
Plastic Surgery	10	20
Psychiatry	106	294
Radiology	70	218
Surgery	146	374
Thoracic Surgery	7	11
Urology	15	44
TOTAL	863	2,431

SOURCE: *Directory of Approved Internships and Residencies*, American Medical Association.

Prepared by:
MSMS Bureau of Economics
January 20, 1977

MSMS Membership Breakdown
Active, life and retired as of Dec. 1, 1976

County	Active	Life	Retired	Total
Allegan	17	1	3	21
Alpena-Alcona-Presque Isle	31	3	2	36
Barry	19	2	2	23
Bay-Arenac-Iosco	87	4	9	100
Berrien	122	7	5	134
Branch	23	5	1	29
Calhoun	106	10	19	135
Cass	8	0	1	9
Chippewa-Mackinac	15	4	3	22
Clinton	12	0	0	12
Delta-Schoolcraft	26	6	2	34
Dickinson-Iron	23	5	1	29
Eaton	11	2	2	15
Genesee	345	26	16	387
Gogebic	8	4	0	12
Grand T-Lelanau-Benzie	99	2	6	107
Gratiot	25	3	1	29
Hillsdale	11	1	3	15
Houghton-Baraga	25	2	4	31
Huron	19	1	0	20
Ingham	314	29	19	362
Ionia-Montcalm	26	3	1	30
Isabella-Clare	34	1	3	38
Jackson	119	11	11	141
Kalamazoo	302	15	20	337
Kent	489	37	11	537
Lapeer	21	1	3	25
Lenawee	24	2	2	28
Livingston	6	0	2	8
Macomb	257	5	6	268
Manistee	12	1	1	14
Marquette-Alger	73	4	3	80
Mason	23	2	2	27
Mecosta-Osceola-Lake	14	0	2	16
Menominee	7	2	0	9
North Central	31	0	3	34
Midland	76	0	3	79
Monroe	52	7	3	62
Muskegon	115	7	16	138
Newaygo	6	2	0	8
Northern Michigan	86	2	4	92
Oakland	854	30	22	906
Oceana	8	0	1	9
Ontonagon	6	0	0	6
Ottawa	79	4	12	95
Saginaw	197	3	14	214
St. Clair	72	5	4	81
St. Joseph	26	1	2	29
Sanilac	9	4	1	14
Shiawassee	36	1	3	40
Tuscola	9	2	1	12
Van Buren	23	2	3	28
Washtenaw	413	32	15	460
Wayne	2,577	366	104	3,017
Wexford	23	0	1	24
	7,350	642	382	8,374

SOURCE: MSMS Bureau of Economics

(Continued on page 406)

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143 Cortland Avenue, Rockford, 49341, Telephone (616) 866-9395

BURNS CLINIC MEDICAL CENTER

ANNUAL MEDICAL MEETING

To Be Held At Boyne Highlands
Harbor Springs, Michigan
September 30, 1977 — Friday 8:30 a.m.
October 1, 1977 — Saturday 8:30 a.m.

SEMINAR TOPICS AND GUEST LECTURES WILL INCLUDE:

EYE SEMINAR — HONORING *William S. Conway, M.D.*
Diabetic Retinopathy — *Morton S. Cox, M.D.*
Director, Retina Service
University Hospital
Ann Arbor, Michigan

TRAUMA SEMINAR
Chest Injuries — *Thomas E. Williams, Jr., M.D.*
Associate Professor of Surgery
Division of Thoracic Surgery
Ohio State University, Columbus

Closed Head Injuries — *R. Harris Russo, M.D.*
Assistant Professor of Neuro Surgery
University of Michigan Medical School, Ann Arbor

INTERNAL MEDICINE SEMINAR — HONORING *Benjamin B. Blum, M.D.*
Update on Inflammatory Bowel Disease — *William S. Haubrich, M.D.*
Head, Division of Gastroenterology
The Scripps Clinic & Research Foundation
LaJolla, Clinical Professor of Medicine
University of California, San Diego

CARDIOLOGY SEMINAR
Monitoring Pulmonary Artery Pressures in the Acutely Ill — *Daniel T. Anbe, M.D.*, Cardiologist
Henry Ford Hospital, Detroit

Topic to be announced — *Leo M. Henikoff, M.D.*
Acting Vice President for Medical Affairs
Acting Dean, Rush Medical College, Chicago

BANQUET SPEAKER — *Richard C. Bates, M.D., FACP*
Associate Clinical Professor of Medicine, Michigan State
"Auto Pollution"

M.S.M.S. CME Category I Credits: 10 credits will be awarded for attendance of the meeting.

FOR FURTHER INFORMATION:
A.D. Damschroder, M.D., Chairman
Burns Clinic Medical Center
Petoskey, Michigan 49770
Phone: (616) 347-7000 — Ext. 500

Registration fee for the meeting is $50.00.

REGISTRATION FORMS AND DETAILED PROGRAM WILL BE AVAILABLE IN AUGUST 1977.

WSU research shows female MDs increasing output

"Superwoman" is the name for the woman physician who cares for her patients while also playing the traditional roles of wife and mother, says a report in the June 6 *Journal of the American Medical Association.*

Marilyn Heins, MD, of Wayne State University School of Medicine, reports on a continuation of her studies in productivity of women and men physicians.

Doctor Heins concludes there has been an increase in productivity of women physicians in the past 10 to 20 years, at the same time more of the women in medicine married and had children.

"Increased productivity in the face of greater family responsibilities seems to illustrate the 'superwoman' role that many women physicians play," says Doctor Heins.

Doctor Heins studied the working habits of groups of men and women doctors, and determined that women physicians work nearly 90 percent as much as do men physicians. And the difference is largely due to time out for child bearing and child rearing by the woman doctors, she says.

At the time of the survey, 96 percent of the men and 84 percent of the women were working at the practice of medicine. Most of those of both sexes not working were ill or retired. Only seven percent of the nonworking women physicians were not working for reasons related to the traditional female role: marriage, childbirth, or child rearing.

Michigan Medical School Students' Place of Residence Entering Class 1976-77

County	U-M	WSU	MSU	Total
Alcona	—	—	1	1
Allegan	1	—	—	1
Baraga	1	1	—	2
Bay	1	—	—	1
Berrien	3	5	—	8
Calhoun	—	1	1	2
Delta	1	—	—	1
Dickinson	1	1	—	2
Eaton	1	1	—	2
Genesee	11	5	2	18
Grand Traverse	2	3	—	5
Gratiot	—	—	1	1
Hillsdale	1	—	—	1
Houghton	—	—	1	1
Huron	—	1	—	1
Ingham	9	12	35	56
Iosco	1	—	—	1
Isabella	1	—	—	1
Jackson	1	4	—	5
Kalamazoo	7	2	1	10
Kent	10	13	2	10
Livingston	2	1	—	3
Mackinac	—	—	2	2
Macomb	5	18	1	24
Marquette	4	—	3	7
Menominee	—	—	1	1
Midland	3	4	—	7
Monroe	—	—	2	2
Montcalm	1	—	—	1
Muskegon	3	2	2	7
Newaygo	1	—	—	1
Oakland	47	75	14	136
Oscoda	1	1	—	2
Otsego	1	—	—	1
Ottawa	—	2	—	2
Saginaw	—	—	1	1
St. Clair	—	2	—	2
Sanilac	—	1	—	1
Schoolcraft	1	—	—	1
Shiawassee	1	2	—	3
Tuscola	—	1	—	1
Washtenaw	33	14	4	51
Wayne	43	72	17	132
TOTAL MICHIGAN COUNTIES	198	244	91	533
State or Country				
Arizona	—	1	1	2
California	6	1	5	12
Florida	3	1	—	4
Illinois	2	—	1	3
Massachusetts	—	1	1	2
Missouri	2	—	1	3
New Jersey	1	1	1	3
New York	15	2	2	19
Ohio	3	1	—	4
Texas	2	—	—	2
Other states	4	1	3	8
Africa	—	3	—	3
TOTAL OUT-OF-STATE	38	12	15	65
GRAND TOTAL	236	256	106	598

Source: Michigan Health Counci

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COMPOUND c̄ CODEINE #3

Each tablet contains: codeine phosphate, 32 mg (gr ½), (Warning: May be habit-forming); aspirin, 227 mg; phenacetin, 162 mg; and caffeine, 32 mg. CIII

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Plus CIII prescribing convenience: up to 5 refills in 6 months (where state law permits), and telephone prescribing permissible in most states. See page 3 of advertisement for prescribing information.

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Introducing the peach-colored acetaminophen/codeine tablet

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c̄ CODEINE #3

Each tablet contains: codeine phosphate, 30 mg (gr ½),
(Warning: May be habit-forming); and acetaminophen, 300 mg. CIII

Empracet c̄ Codeine #3: non-aspirin/codeine pain reliever for aspirin-sensitive patients

EMPRACET c̄ Codeine #3 offers you an alternative with advantages for your aspirin-sensitive patients, those with bleeding disorders and "...patients undergoing surgical procedures associated with significant blood loss such as tonsillectomies, open heart surgery, and scoliosis repair...."*

NEW LOOK

Not the same old green and black capsule with a "revised formula." Not a white tablet with aspirin-associations. New peach-colored EMPRACET c̄ Codeine #3 looks different from the leading codeine combination products. It doesn't contain aspirin, so it doesn't look like aspirin—imparting greater reassurance to patients leary of taking it by mistake. It also avoids confusion with other tablets in the household.

NEW NAME

Not a household word, the new name may play a positive role in your pain patient's subjective reaction to your prescription.

EMPRACET c̄ Codeine #3. New look. New name. Psychologically more acceptable to your patients. And with CIII prescribing convenience for you—up to 5 refills in 6 months at your discretion (where state law permits), and telephone prescribing permissible in most states.

*Czapek EE: *JAMA 235*:636, 1976.

EMPIRIN® COMPOUND with CODEINE ⒸIII

Contraindications: Hypersensitivity to aspirin, phenacetin, caffeine or codeine.

Warnings: See Warnings below.

Precautions: *Allergic:* Precautions should be taken in administering salicylates to patients with active peptic ulcers and those with known allergies; patients with nasal polyps are especially likely to be hypersensitive to the medication. SEE ADDITIONAL PRECAUTIONS BELOW.

Adverse Reactions: Most frequent adverse reactions are listed below. Some patients taking salicylates develop nausea and vomiting. Hypersensitivity may be manifested by skin rash or anaphylactic reaction. With these exceptions, most side effects occur after repeated administration of large doses; include headache, vertigo, ringing in ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin.

Phenacetin side effects usually result from overdosage. Cyanosis, acute hemolytic anemia, skin lesions, and fever may appear with toxic doses. Continued abuse may lead to renal damage.

Caffeine side effects almost always result from overdosage; include insomnia, restlessness, excitement, tense muscles, and diuresis. Tachycardia and extra systoles may be observed.

EMPRACET™ with Codeine Phosphate, 30 mg, No. 3 ⒸIII

Contraindications: Hypersensitivity to acetaminophen or codeine.

WARNINGS, PRECAUTIONS, ADVERSE REACTIONS AND DRUG INTERACTIONS COMMON TO BOTH PRODUCTS

Warnings: *Drug dependence.* Codeine can produce drug dependence of the morphine type and may be abused. Dependence and tolerance may develop upon repeated administration; prescribe and administer with same caution appropriate to oral narcotics. Subject to the Federal Controlled Substances Act.

Usage in ambulatory patients. Caution patients that these products may impair mental and/or physical abilities required for performance of potentially hazardous tasks such as driving a car or operating machinery.

Interaction with other CNS depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both.

Usage in Pregnancy. Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.

Precautions: *Head injury and increased intracranial pressure.* Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal condition. These products or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

Special risk patients. Administer with caution to certain patients such as elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.

Adverse Reactions: Most frequently include lightheadedness, dizziness, sedation, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; others include: euphoria, dysphoria, constipation and pruritis.

Drug Interactions: CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For symptoms and treatment of overdosage and full prescribing information, see package insert.

Wellcome

Burroughs Wellcome Co.
Research Triangle Park
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Empracet
c̄ Codeine #3
Empirin Compound
c̄ Codeine #3

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COLBY PROCLAIMS WOMAN SUFFRAGE

Signs Certificate of Ratification at His Home Without Women Witnesses.

MILITANTS VEXED AT PRIVACY.

Wanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—
[illegible] struggle for Wom-

VOTERS
REGISTER HERE

NEW YORK THURSDAY, AUGUST 15,

Social Security Bill Is Signed
Gives Pensions to Aged, Jo

Roosevelt Approves Message Intended to Benefit 30,
Persons When States Adopt Cooperating Laws-H
the Measure 'Cornerstone' of His Economic Prog

WASHINGTON, Aug.
The Social Security Bill,
a broad program of une
insurance and old age
and counted upon to be
20,000,000 persons, beca
day when it was signed
dent Roosevelt in the
those chiefly responsib
ting it through Co

Mr. Roosevelt cal
"the cornerstone
which is being
me s compl

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sent

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TRUMAN CLOSES
ITED NATIONS CONFERENC
WITH PLEA TO TRANSLATE
CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

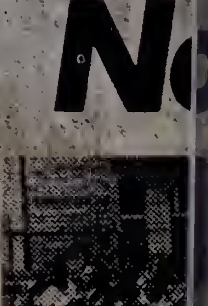
Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

SIGN
the Dra
Ends N

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the



PATIENT PACKAGE INSERTS: A ONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST, N W, WASHINGTON, D C 20005

Heartbeat

By Mert Scholten
MSMS Communications Department

Richard Antell, MD, Flint, is new president-elect of the Michigan Heart Association.

Roland R. Benson, MD, Grand Rapids, has been honored by St. Mary's Hospital which has named its diagnostic radiology unit for him. Doctor Benson, a radiologist, was director of radiology, 1946-1966, and currently is a department member. A portrait of Doctor Benson hangs in the unit.

Dean C. Burns, MD, Petoskey, director emeritus, Burns Clinic, is the recipient of the University of Chicago Alumni Association's prestigious Public Service Citation. The citation honors his creative citizenship and exemplary leadership in community service which has benefited society and reflected credit upon the University.

John M. Dorsey, MD, WSU professor emeritus, was recently presented a Distinguished Service Award from the WSU School of Medicine. A student of Sigmund Freud, Doctor Dorsey served as chairman of the Department of Psychiatry at Detroit General Hospital from 1946 through 1961 and became WSU's first University Professor in 1961. An active writer, Doctor Dorsey has published a number of books on Freud as well as personal memoirs.

John V. Fopeano, MD, Kalamazoo, is a recipient of the Kalamazoo Rotary Club's 1977 "Red Rose Citation" for outstanding community services. Now retired, Doctor Fopeano has served as director of the Senior Citizens Fund and the Kalamazoo Visiting Nurses Association. He also is past president of the Kalamazoo Academy of Medicine and received an MSMS Certificate of Commendation in 1971.

Boy Frame, MD, Detroit, head, Fifth Medical Division at Henry Ford Hospital, is new governor-elect of the American College of Physicians — Michigan Chapter. Following a year as governor-elect, he will serve a four year term as governor.

Daniel R. Guyot, MD, Grosse Ile, Harper Hospital radiologist, has been awarded the "outstanding clinical faculty award" by this year's senior class of WSU's School of Medicine.

Robert S. Holm, MD, Grand Rapids, is new chairman, Michigan Chapter, American Academy of Pediatrics.

Tom M. Johnson, MD, Grand Rapids, former MSU College of Human Medicine Dean for the Grand Rapids campus, has become the Dean of the University of North Dakota School of Medicine. He has been active on various MSMS committees including the Committee on Public Service and the Committee on Medical Aspects of Organized Athletics.

Karl S. Klicka, MD, Wayne, recently retired executive director, Peoples Community Hospital Authority, is recipient of the Michigan Hospital Association's highest honor — the Key Award for Meritorious Service.

Louise L. Liang, MD, Grosse Pointe Park, head, Division of Pediatrics and Adolescent Medicine, Henry Ford Hospital Dearborn Branch, is a White House Fellow for 1977-78. She is one of 14 chosen by President Carter from among more than 1,300 applicants. Doctor Liang, at 28 the youngest of the fellows appointed, will begin her year of service with the government on Sept. 1.

A. Rees Midgley Jr., MD, Ann Arbor, professor of anatomy, U-M Medical School, is recipient of the Ayerest Award for distinguished service in the field of endocrinology for 1977. The $1,000 honorarium is given every four years to worthy young endocrinologists to help defray their costs in attending the International Congress of Endocrinology.

Fazlolah Nickhah, MD, Ypsilanti, is head team doctor for the Amateur Athletic Union's wrestling team. The team will compete in the world free-style championships and the world Greco-Roman championships in October in Switzerland and Sweden, respectively.

Frederick C. O'Dell, MD, Alpena general surgeon, is president, Michigan Chapter, American College of Surgeons.

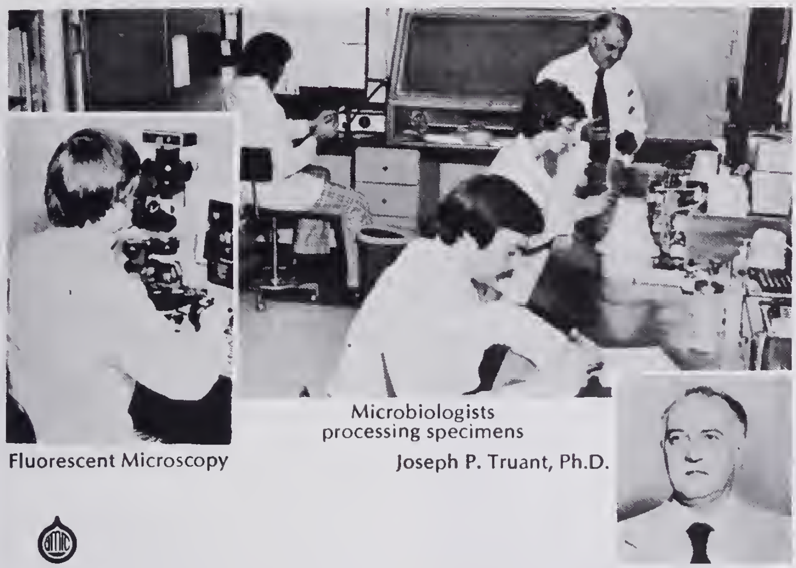
Kenneth Pierce, MD, Dowagiac, is recipient of the Dowagiac Rotary Club's Keyway Award for his outstanding contributions to his community and the Rotary organization.

Richard W. Pomeroy, MD, Lansing, is new president, Michigan Association for Medical Education (MAME).

Robert S. Schindler, MD, Berrien Center, general surgeon and chief of staff at Berrien General Hospital, is returning to Africa for three months of medical missionary duty in Monrovia, Liberia, at the hospital he founded in 1962.

David Siegel, MD, Lansing urologist and vice-speaker, MSMS House of Delegates, is also president, Michigan Branch, American Urological Association, Inc.

* **AMRC** Microbiology Department *



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Doctor Cook in "the world's largest filing cabinet."

How one Michigan doctor beat the 'medical menopause'

By Willah Weddon
***Special to* Michigan Medicine**

About five years ago Carlton L. Cook, MD, looked around his office in Tecumseh and decided he was in what he now refers to as a "medical menopause."

"I think most physicians reach this stage at some time in their lives," he said thoughtfully. "You feel you've done what you set out to do when you left school. Your family is mostly grown, you're an economic success and you discover all you have left to do is keep plodding along in the same old way."

"You begin to wonder if you'll be happy doing this a lot longer," mused the family physician with a quiet smile.

In Doctor Cook's case, he made a decision to change a number of things and went into action.

Several changes

His first step was a return to delivering babies. He'd given up this portion of his practice a few years previously and had missed it. He began to schedule obstetric patients for appointments in the late morning hours, time formerly set aside for hospital rounds.

These expanded office hours were possible because Tecumseh's Herrick Memorial Hospital now had resident physicians on duty from 6:30 p.m. until 5:30 a.m. Not being "on call" permitted Doctor Cook to commit himself to a more rigid routine.

He soon discovered, however, he needed more help in the office and more space to file patient records. So he added to his office, expanding from one to three examining rooms. These were designed around an "island" or communications center which allows him freedom of movement. As he moves from one examining room to another he has contact with his staff at the island and has found it makes much more efficient use of his time.

The addition enabled him to alter a room to what he calls the world's largest filing cabinet. The entire eight-by-twelve-foot room is lined with shelves holding patients' color-coded files. "If I live to be 75, I'll still have enough room," he said, chuckling.

His staff was enlarged to three full-time employees and although his expenses increased, his income increased too.

"This was a help," he said, "because by then three of our six children were in college."

Doctor Cook was born in Sturgis and raised on a farm near White Pigeon. His inspiration was a family doctor in Centerville, "who did everything," and he's tried to retain this person-to-person concept in his practice.

A graduate of Michigan State University, Doctor Cook served in the U.S. Army Air Corps and attended the University of Michigan Medical School. During the summer of 1951, between his junior and senior year, he was the first extern at the Tecumseh Hospital.

"My wife (Lynn) was nine months pregnant, we borrowed her father's house-trailer and parked it outside town," he recalled. "And the people here were good to us."

Although he began practice in a partnership with Louis May, MD, in Howell, within six months two Tecumseh physicians loaned him money to start his solo practice in their area. That was nearly 24 years ago. Since that time he has served on the city council for eight years and has been active on the Presbyterian Church Board. "I would have felt bad if I'd not offered to serve in some form," he said. "This town has been great to us."

'Family practice'

The Cooks' children have all worked in his office for about two years each, starting at the age of 14.

"I wasn't home much and wanted them to know what their old man was doing to earn a living for the family," he explained. He hasn't tried to influence his children to enter the medical field. "They can see what it's like and if they don't like it, they don't have to."

The experience apparently has had an effect, however, as (from eldest down) Patricia (Schmidt) is a Registered Nurse, Catherine a second year student at MSU Osteopathic College, April a registered nurse at Lansing General Hospital, Jennifer starting her senior year at St. Vincent's Nursing School in Toledo, William entering U of M's pre-medical courses in the fall and Margaret will be a junior in high school.

The family influence has extended to 10 medical students from the U of M who have spent four to six weeks with the Cooks during summers and worked in Doctor Cook's office. They've also had an exchange student from Finland and one from France living and working with them in two consecutive summers, adding to the concept of a "family practice."

When the Cooks have time for recreation they like to fly their Cherokee Arrow airplane. Doctor Cook is a vice president in the Flying Physicians Association and Lynn is active in the "99's," a state and national organization of women flyers. Doctor Cook's interest in this field has recently led to another stimulating aspect of his practice. Doctor Cook has been designated a class I examiner for commercial airline pilots.

For the 1.2 mile trip between home and office, however, Doctor Cook pedals a bicycle. (In good weather he makes the ride back and forth to lunch, too.) As he hoisted his 185-pound, five-foot ten-inch frame to the cycle seat, a smile spread across his face.

"My wife won't let me have a motorcycle," he confided. "But she lets me fly."

Meetings

(See also listing of Category I programs on page 436.)

Sept. 5 – MSMS/INTRAV Around-the-World Adventure, contact: Marce Ireland, MSMS headquarters.

Sept. 7 – MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS director.

Sept. 12 – MSMS/INTRAV Orient Adventure, contact: March Ireland, MSMS headquarters.

Sept. 17 – Michigan Society of Pathologists September Seminar, "Renal Disease," St. John Hospital, Detroit, contact: John F. Dunkel, MD, Department of Pathology, MSU, East Lansing, 48823.

September 17-18 – Leadership Training Seminar, American Association of Medical Assistants, Holiday Inn, St. Joseph, contact: Claire E. Van Dam, 1591 S. Riviera Drive, Stevensville, 49127.

Sept. 23-24 – Reunion, Medical Center (all classes), 5-year Classes (1927-1972) Medical and Nursing, University of Michigan, contact: Alumni Association Office, (313) 764-0384.

Sept. 29-30 and Oct. 1 – "Implant Surgery for Joints and Tendons in the Hand," sponsored by American Society for Surgery of the Hand, Blodgett Memorial Medical Center, Grand Rapids, contact: Blodgett Memorial Hospital, (616) 774-7444.

September 30 – Michigan Society of Internal Medicine Annual Meeting, Hidden Valley, Gaylord, contact: Jack Kanter, Ingham County Medical Society, P.O. Box 770, East Lansing, 48823, 517/332-8021.

October 2 – American College of Physicians meeting, Hidden Valley, Gaylord, contact: Jack Kantner, Ingham County Medical Society, P.O. Box 770, East Lansing, 48823, 517/332-8021.

Oct. 10-11 – First Ann Arbor Symposium on Biology of Special Senses in Aging, Institute of Gerontology, the University of Michigan-Wayne State University, contact: Dorothy H. Coons, Symposium, Institute of Gerontology, University of Michigan, 520 E. Liberty, Ann Arbor, 48109.

Nov. 2 – MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS director.

Nov. 8-9-10 – MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Herb Auer, MSMS headquarters.

Dec. 14 – MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS director.

Medical school deans report on their activities

By Ralph Lewis, executive director
Michigan Medical Schools Council of Deans

The Michigan Medical Schools Council of Deans represents a continuing effort by Michigan's four state-supported medical schools to come together jointly and by their own initiative to discuss, cooperatively plan, and evaluate medical education in the State of Michigan. This is done through a number of mechanisms:

- Monthly meetings of the Council of Deans
- A yearly two-day retreat of the Council of Deans
- Periodic meetings with faculty and administrative groups from the four medical schools
- Project development and operation
- Participation with state government, state professional organizations, and other units on cooperative efforts

During the past months we have been intensively involved in major activities at the state level:

1. **Prison Health** - Through "boiler plate" language in the FY 1976 Higher Education Appropriations bill, the Michigan legislature directed that the medical schools develop a plan for providing health care to inmates of Michigan correctional institutions. My office has been the focal point for discussions between the medical schools and the Department of Corrections' Office of Health Care; a recent hearing with Senator Earl Nelson resulted in a position statement by each medical school on current and future involvement in this program.

2. **Medical malpractice** - A continuing problem with the medical schools, this issue hit crisis proportion in 1976 with malpractice coverage being difficult to obtain and that which was available being extremely expensive. A letter to Governor Milliken by the presidents of the three universities with medical schools, continuing contact with staff of the governor's office by Council of Deans staff, a subcommittee of the Council of Deans, a late 1976 fact-finding hearing with staff from Representative Bobby Crim's office, and a letter and charge from the Governor asking that the Council of Deans identify the nature and scope of the malpractice problem and recommend specific alternatives to ease the problems, has increased and focused our activities.

3. Approval has been received from the National Fund for Medical Education for a six month extension of the grant to "Develop a Financial Aid **Data Network**." The system will be ready to accept data on the entering classes of medical students in the fall of 1977.

4. The **Fourth Annual Health Professions Advisors' Day** centered on the New MCAT; over 100 advisors, science faculty, and admissions committee members from throughout Michigan attended the November program.

5. The Educational Affairs Committee through the curriculum deans formalized a **basic science interchange agreement**, similar to the existing clerkship agreement. A two-year grant from the National Fund for Medical Education to develop an "Education Resources Sharing Network" was funded and will begin July 1, 1977.

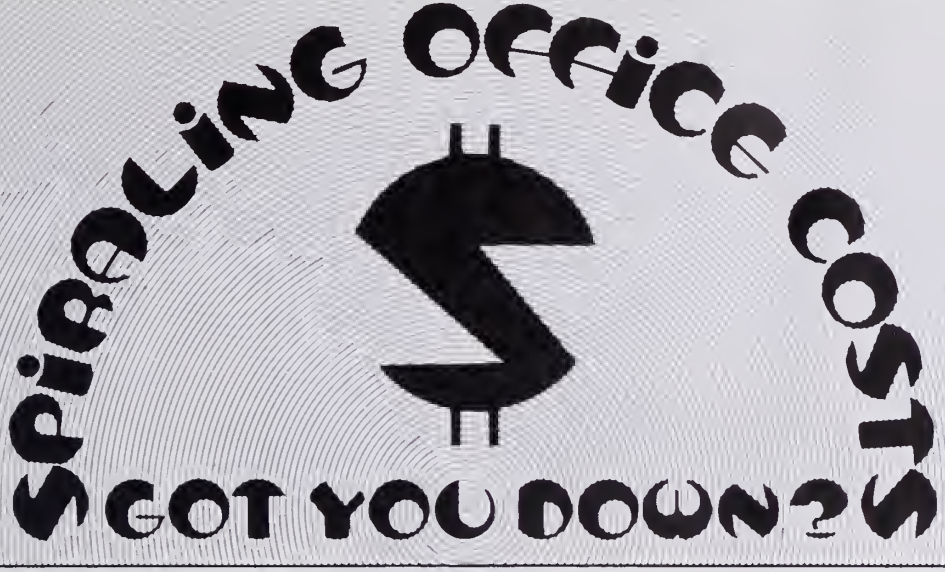
6. **Graduate training** - Continuing staff and financial support to the developing Statewide House Officers Training System as it incorporated and began operation, has gotten the program off the ground. A three-year grant from the W. K. Kellogg Foundation was funded on November 1, 1976.

7. Periodic meetings with medical school continuing medical education staff, public information officers, financial aid officers, preceptorship staff, student affairs officers, and others, help to keep lines of **communication** open and encourage and facilitate cooperation between medical schools.

8. Staff keeps up-to-date on Michigan and national **legislation** relating to medical education, relays this information to the Council of Deans, and initiates and participates in appropriate discussion and action.

In addition to bringing the deans and faculty representatives together, the existence of the Council of Deans indicates the interest in and commitment to continued voluntary cooperation on the part of Michigan's four state-supported medical schools. The Council provides a forum for discussion, cooperative planning, and evaluation of various aspects of medical education in Michigan.

A direct benefit of the Council is the ability to rapidly respond to, and mobilize to meet, requests for assistance and information from state government (medical malpractice, prison health) and other groups. The Council can also effectively be a forum for continually reviewing areas where cooperation is occurring (financial aid data network, preprofessional advising, statewide house officers training system development, cost study, education resources sharing network) between medical schools.



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Upjohn and Bronson Hospital join in unique clinical research

By James Shamp
Special to Michigan Medicine

The "kids next door" eyed each other for years. They watched each other grow. Occasionally, their talks on lazy summer afternoons even touched on the idea of a marriage.

Then, in 1973, researchers from the Kalamazoo-based Upjohn Company and officials of Bronson Methodist Hospital "tied the knot" in a marriage unique to clinical research.

They formed the Bronson Clinical Investigational Unit (BCIU), and are now "keeping house" in — a $2 million, 29,000-square-foot clinic encompassing the entire fifth floor of a newly constructed Bronson wing.

BCIU, a wholly-owned subsidary of the hospital, is fully funded by Upjohn. It provides the entire Kalamazoo medical community with an unusual opportunity to conduct clinical research outside the traditional university setting. It also gives many Upjohn research physicians a "company clinic" in which they can keep up-to-date with clinical procedures.

With its regular professional staff of three physicians and 20 registered nurses, the BCIU conducts studies initiated by hospital staff nurses and physicians anywhere in the Kalamazoo community as well as those initiated by Upjohn staff researchers. It also has been made available to a few local college faculty members for medically related studies.

Informed consent videotape viewing by volunteer subjects at the Bronson Clinical Investigation Unit, Kalamazoo.

Raymond M. DeHaan, MD, medical director of the BCIU, says approximately 150 research protocols have been conducted at the fledgling research facility, nearly half of them considered "major" studies.

A pool of some 2,000 normal volunteers has been generated for BCIU studies. Most are employees of Bronson and Upjohn, or students at Western Michigan University. The normals are paid varying rates, depending on the potential discomfort and inconvenience involved in a given protocol.

A new 14-bed inpatient section on the unit makes it easy to monitor inpatient volunteers whose diagnoses relate to a study being conducted at the BCIU. Inpatient volunteers aren't paid, but they are given free medical care.

Jack Weiner, PharmD, BCIU administrative manager, says one of his main tasks now is to orient the local medical community toward using the new research facility for studies relating to their daily clinical practices.

"A lot of physicians think only of checking the literature for answers to their questions," says Weiner. "It doesn't occur to them that they can come up with some of the answers themselves, with the help of the BCIU staff."

Last year, eight hospital-based physicians conducted studies in conjunction with BCIU, as did five other community-based researchers. In all, 20 protocols unrelated to Upjohn activities have been conducted by the BCIU staff for community-based physicians.

The BCIU staff offers community physicians as little or as much involvement in their studies as the participating physicians have time for. Monthly clinical pharmacology programs are being set up by the BCIU staff, to increase involvement of the local medical community in the BCIU's continuing education potential.

"I've found the BCIU to be a valuable asset," says Thomas Burkhardt, MD, a Bronson staff pathologist par-

(Continued on page 423)

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ossibly Effective: Management of vertigo associated with diseases affecting the
stibular system.

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CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

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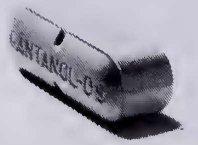

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s (primarily pyelonephritis, pyelitis and cystitis) due to
ceptible organisms (usually *E. coli, Klebsiella-Aerobacter,*
hylococcus, *Proteus mirabilis* and, less frequently,
eus vulgaris), in the absence of obstructive uropathy or
ign bodies. Note: Carefully coordinate *in vitro* sul-
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throat, fever, pallor, purpura or jaundice) may indi-
serious blood disorders. Frequent CBC and urinalysis
microscopic examination are recommended during
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pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

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Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

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* Warning
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: **Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K$^+$ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K$^+$ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K$^+$ frequently; both can cause K$^+$ retention and elevated serum K$^+$. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.*
SERUM K$^+$ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

SK&F CO., Carolina, P.R. 00630

SK&F CO.
a SmithKline company

Doctor Haan

ticipating in a BCIU protocol involving differential testing for B and T lymphocytes. "Patients here can benefit greatly from it, because we can use the BCIU for some testing that wouldn't normally be available in community hospitals the size of Borgess or Bronson hospitals here."

Kalamazoo oncologist Leo Zelkowitz, MD, recently found a home for the city's first plasmaphoresis unit at BCIU, calling it "A clear-cut example of BCIU willingness to use its facilities to develop improved care for the community."

The BCIU has conducted varied types of protocols, including testing new methods of insulin administration for children in diabetic comas, behavior modification for treating obesity and investigations of atherosclerosis, hypertension and acne treatment.

The BCIU staff has also helped to cut through red tape to help local physicians initiate new therapeutic and diagnostic techniques within the hospital.

In spite of the experimental nature of the BCIU's activities in these days of sensitive medical liability problems, Dr. DeHaan says there has never been a legal action filed against the facility.

One reason for BCIU's lack of legal hassles, he believes, is the unit's establishment of an extensive evaluation and informed consent process.

Every research proposal brought to the BCIU must go through myriad staff members and committees — including the Human Use Committee, made up of several community-based physicians, a local attorney, a social worker and a local clergyman.

Video-taped informed consent lectures are presented to all volunteers before a protocol begins. Volunteers are then given questionnaires, so the staff knows they fully understand the reasons, risks and requirements surrounding the study. The video tapes are stored in case they're needed for review by volunteers, and to provide a complete record of the contents of the informed consent. The BCIU staff has also taped enactments of some technical procedures used in protocols, to decrease the chance for misunderstanding by volunteers.

Volunteers also receive free histories and physicals which, at their request, are then given to their private physicians.

The BCIU also submits its proposals to a clinical pharmacologist at Michigan State University for an objective review before starting a protocol.

"We feel it's our responsibility to promote as much high-quality research as possible," says Dr. DeHaan.

"We find that a number of physicians who consider leaving a major medical center to come to a place like Kalamazoo want the option to do research, even if they seldom exercise that option. The BCIU can help them all the way, from writing a protocol through analysis of the findings. We can help Kalamazoo's physicians stay in touch with the clinical research process."

Monthly Surveillance Report

Cases of Certain Diseases
Reported to the Michigan Department of Public Health

For the Five-Week Period Ending July 1, 1977

	1977 This 5-Week Period	1976 Same 5-Week Period	1977 Total To Above Date	1976 Total Same Date	Total Cases for 1976
Rubella	173	205	871	1,270	1,513
Cong. Rubella Syndrome	2	0	2	0	2
Measles	110	1,137	858	5,406	6,139
Whooping Cough	2	9	16	41	70
Diphtheria	0	0	0	0	0
Mumps	334	556	1,750	4,723	5,507
Scarlet Fever & Strep Sore Throat	2,261	2,312	18,402	14,628	24,937
Tetanus	0	0	1	0	3
Poliomyelitis (paralytic)	0	0	0	1	1
Hepatitis	263	246	1,500	1,254	2,645
Salmonellosis (other than S. typhi)	84	85	448	409	889
Typhoid Fever (S. typhi)	2	2	9	6	10
Shigellosis	31	50	178	297	550
Aseptic Meningitis	7	8	38	49	163
Encephalitis	4	4	22	37	77
Meningococcic Meningitis	4	8	28	43	65
H. Influenza Meningitis	24	22	83	75	134
Tuberculosis	117	145	682	679	1,357
Syphilis	113	78	592	555	1,066
Gonorrhea	3,788	3,286	16,599	16,152*	34,829

Information can be supplied by the local health department on local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

*Correction

250
230
210
190
170
150
130
90
Lidov

When choosing a diuretic for day-in-day-out hypertension control with comfortable compliance...

The agent you choose in mild to moderate essential hypertension should offer (1) long-term effectiveness, (2) patient comfort and compliance.

Zaroxolyn offers both.

In one long-term study[1] Zaroxolyn brought moderately elevated (average 161/109 mm Hg) blood pressure down to the range of normotension—and held it there for a year or more.

The investigator noted, "Patient cooperation was surprisingly good for a study of such duration [2½ years]. The once-daily dosage schedule with metolazone [Zaroxolyn] no doubt contributed to patient compliance."

Overall compliance with Zaroxolyn is good—very good. An analysis of controlled clinical studies involving 188 Zaroxolyn patients showed that only eight discontinued therapy because of side effects. That's a discontinuation rate of only 4.3%, and broader clinical experience appears to substantiate this low rate.[2]

Zaroxolyn. For long-term control and comfortable compliance in mild to moderate hypertension.

Recommended initial dosage in mild to moderate essential hypertension–2½ to 5 mg once daily

Zaroxolyn®

(metolazone, Pennwalt)

2½-mg, 5-mg and 10-mg tablets

once-daily antihypertensive diuretic

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents Also, edema associated with heart failure and renal disease. **Contraindications:** Anuria, hepatic coma or precoma; allergy or sensitivity to Zaroxolyn. Or, as a routine in otherwise healthy pregnant women. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated Considerable potentiation may occur when given concurrently with furosemide When used concurrently with other antihypertensives, the dosage of the other agents should be reduced Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia Administration to women of childbearing age requires that potential benefits be weighed against possible hazards to the fetus Zaroxolyn appears in the breast milk Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Hyperglycemia and glycosuria may occur in latent diabetes Chloride deficit and hypochloremic alkalosis may occur Orthostatic hypotension may occur Dilutional hyponatremia may occur in edematous patients in hot weather **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg, edema of cardiac failure—5 to 10 mg, edema of renal disease—5 to 20 mg Dosage adjustment may be necessary during the course of therapy **How Supplied:** Tablets, 2½, 5 and 10 mg

References:

1 Dornfeld L, Kane R. Metolazone in essential hypertension The long-term clinical efficacy of a new diuretic *Curr Ther Res* **18**: 527-533, 1975
2 Data on file, Medical Department, Pennwalt Prescription Products

PENNWALT

Pennwalt Prescription Products
Pharmaceutical Division
Pennwalt Corporation
Rochester New York 14603

County Societies

The **Kent County Medical Society** has added a new feature to its legislators. One of the KCMS delegates or alternates to the MSMS House is invited as a special guest to help provide that doctor with more insights into medical legislation.

* * *

After several years' planning, the **Lenawee County Medical Society** has instituted a medical student loan program to encourage physicians to locate in Lenawee County after their training. A loan of up to $5,000 over a three-year period is available, interest free, to students who qualify. A student must be in the last three years of study and must be co-sponsored by a Lenawee County community where he or she plans to practice. One student from the county already has received money and a second application is pending.

* * *

The **Oakland County Medical Society** has an ambitious goal for itself this year. Members are attempting to obtain information and arrive at a concensus on matters related to medical practice. A committee has been charged with seeking ways to encourage county-wide participation, increased membership and increased turn-outs at meetings . . . Of interest — the OCMS has designated a "No Smoking" area at each of its monthly meetings.

* * *

Marquette County Medical Society was a sponsor of a unique pilot program for 10 persons who had recent heart attacks. The MCMS joined Cardiology Associates and Northern Michigan University's Department of Health, Physical Education and Recreation in a 12-week program of testing, exercise and recreation for the heart attack patients. The experiment was designed to provide treatment while giving physicians and researchers an opportunity to evaluate the capacity of cardiovascular functioning and to study responses to conditioning.

* * *

The **Northern Michigan County Society** has become involved in several community efforts. A $500 contribution was made to a Petoskey counseling center for education to prevent drug abuse. The society contributed $900 to purchase Trainex audio-visual materials for Emergency Medical Technicians at North Central Michigan College.

* * *

To deal with the problem of physician abuses in the provision of laboratory services, the **Oakland County Medical Society** appointed an ad hoc committee. The committee met, defined the problem, investigated the entire matter and issued a preliminary report on its findings. It developed a list of nine ethical standards which should be followed by physicians working in and utilizing laboratories. It also offered suggestions for enforcement of the standards. The committee plans to make its final report public and to ask MSMS for consideration and action.

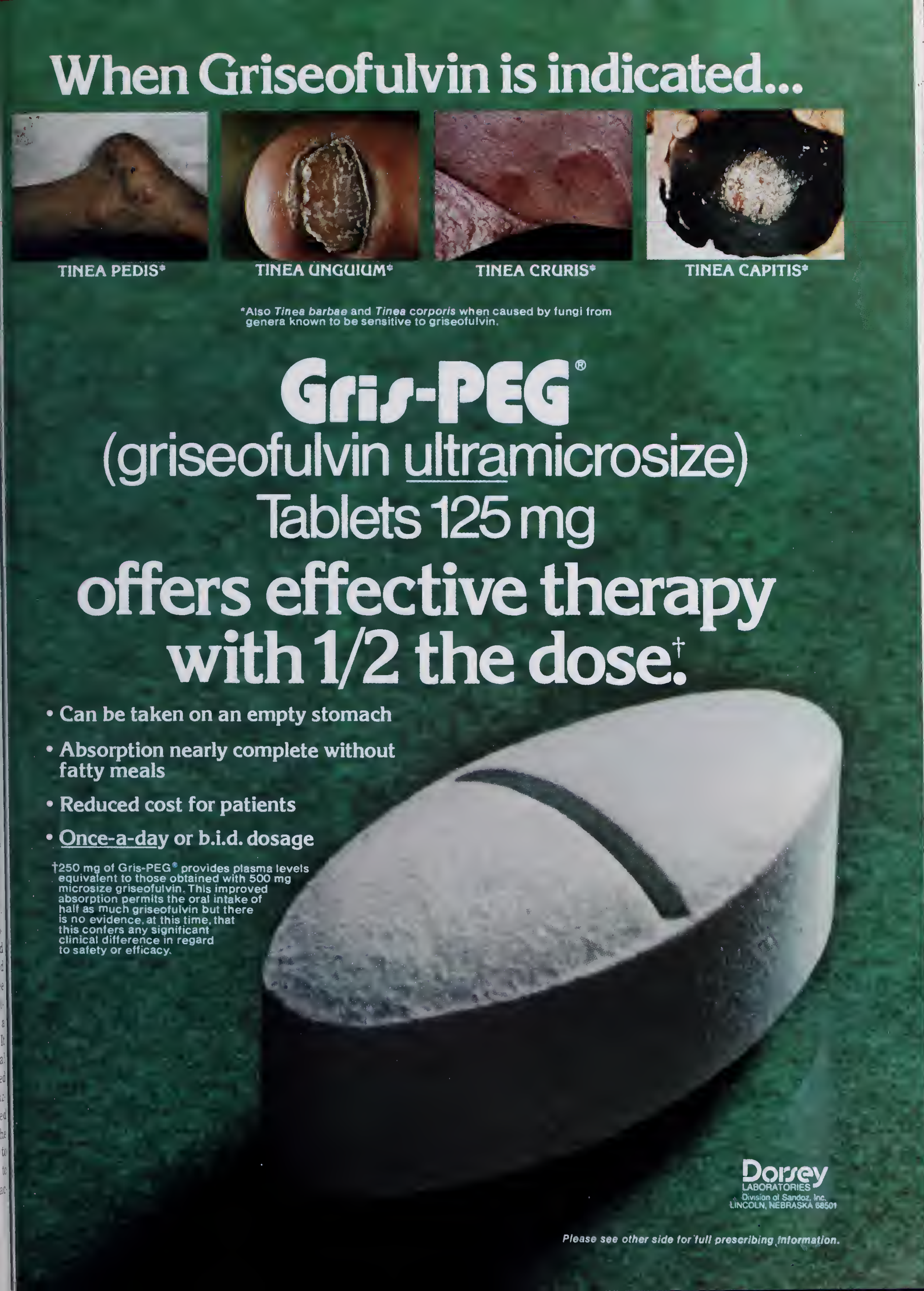
Ohio medical society survey reveals public's view of malpractice

"Greed" or the "desire to get something for nothing" is perceived by Ohio consumers as the primary motivation behind the skyrocketing number of malpractice claims, according to a survey conducted by two Ohio State University professors.

The survey, in which a random sample of 1,500 Ohioans were interviewed, was part of a project launched late last year by Roger Blackwell, PhD, and W. Wayne Talarzyk, PhD, professors of consumer behavior. The purpose of the study, paid by the Malpractice Research Fund of the Ohio State Medical Association, was to assess the attitudes and behaviors of consumers concerning health care and physicians, with special emphasis being placed on evaluating consumer support for various possible solutions to the malpractice problem.

The results of the study have been published in two books: *Consumer Attitudes Toward Health Care and Medical Malpractice,* designed for use by physicians and other health care professionals, and *Consumers Speak About Health Care,* a summary geared toward the general public. The OSMA has urged its members to place copies of this latter book in their waiting and examining rooms and to distribute them to new patients to stimulate doctor/patient communication.

Also available is a slide presentation accompanied by a cassette and a written script prepared by Doctors Blackwell and Talarzyk. For further information, contact the OSMA Department of Communications, 600 S. High St., Columbus, Ohio 43215, 614/228-6971.



When Griseofulvin is indicated...

TINEA PEDIS* TINEA UNGUIUM* TINEA CRURIS* TINEA CAPITIS*

*Also *Tinea barbae* and *Tinea corporis* when caused by fungi from genera known to be sensitive to griseofulvin.

Gris-PEG®

(griseofulvin ultramicrosize) Tablets 125 mg

offers effective therapy with 1/2 the dose.[†]

- Can be taken on an empty stomach
- Absorption nearly complete without fatty meals
- Reduced cost for patients
- Once-a-day or b.i.d. dosage

[†] 250 mg of Gris-PEG® provides plasma levels equivalent to those obtained with 500 mg microsize griseofulvin. This improved absorption permits the oral intake of half as much griseofulvin but there is no evidence, at this time, that this confers any significant clinical difference in regard to safety or efficacy.

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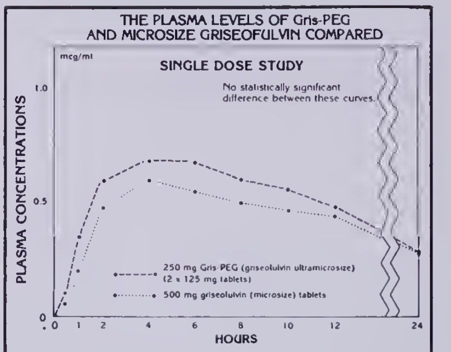
Please see other side for full prescribing information.

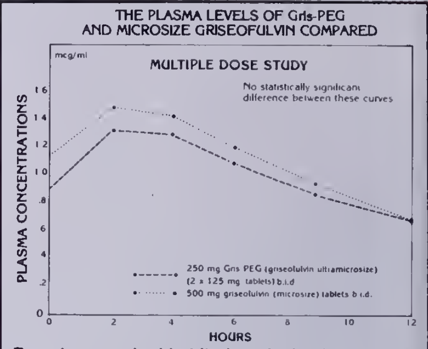
Gris-PEG®

(griseofulvin ultramicrosize) Tablets 125 mg

The ½ dose griseofulvin.



Based on a single dose double-blind bioavailability study conducted in 24 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels. There is no significant difference between peak plasma levels, times to peak, and areas under the curve. Gas chromatographic assay.



Based on a double-blind multiple dose steady state crossover bioavailability study conducted in 17 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels obtained on days 9, 11 and 13. There is no significant difference between times to peak, peak plasma levels, and areas under the curve. Gas chromatographic assay.

DESCRIPTION
Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG Tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION
Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum*, *Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsized griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy.

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS
Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections:

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis, ringworm of the nails)

when caused by one or more of the following genera of fungi.

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleini
Microsporum audouini
Microsporum canis
Microsporum gypseum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified.

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *NOT* effective in the following:

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS
This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS
Prophylactic Usage. Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5 to2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy: The safety of this drug during pregnancy has not been established

Animal Reproduction Studies. It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress. Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS
Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists; however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS
When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion, and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSAGE AND ADMINISTRATION
Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by a culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6 weeks; *tinea corporis*, 2 to 4 weeks; *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months; toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsized) USP (see ACTION Human Pharmacology).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis the following dosage schedule for children is suggested: Children weighing over 25 kilograms (approximately 50 pounds) 125 mg to 250 mg daily; children weighing 15-25 kilograms (approximately 30 to 50 pounds) 62.5 mg to 125 mg daily; children 2 years of age and younger, dosage has not been established.

Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED
Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin microsized tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin, biologically equivalent to 250 mg of microsized griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsized griseofulvin. In bottles of 100 and 500 scored, film-coated tablets

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"my personal commendation" – Gov. Milliken "my personal congratulations" – Dr. Sammons

To MSMS Members,

Thought you would like to read the following letters. The first written by Governor Milliken to MSMS Past President Brock E. Brush, MD, thanking him for his service as chairman of the board of the Brown-McNeely Fund. The Governor sent me a copy of the letter, which I would like to share with all of you.

The second was received in June from the American Medical Association, following elections during the MSMS House of Delegates meeting May 13-15 in Troy.

– Ernest P. Griffin, Jr., MD
Chairman, MSMS Council

Dear Doctor Brush:

Recently I was made aware of the fine tribute the Michigan State Medical Society House of Delegates paid you for your distinguished service as Chairman of the Board of the Brown-McNeely Fund.

Michigan can be thankful that it has weathered its medical malpractice insurance crisis well, and that the prognosis is good for doctors continuing their practices in the state. Certainly, the Malpractice Insurance Fund Board, under your chairmanship deserves the high esteem that physicians hold for you and the Board. I want to add my own personal commendation. I wish you continued success.

Kind personal regards.

Sincerely,

William G. Milliken
Governor, State of Michigan

Dear Doctor Heideman:

May I extend to you my personal congratulations and that of the American Medical Association on your election to President-Elect of the Michigan State Medical Society.

With the number of complexity of issues confronting physicians increasing almost daily, it is absolutely essential that we work together in solving our mutual problems.

If at any time the Association can be of assistance to you in this very important leadership position, please do not hesitate to call on us.

Sincerely,

James H. Sammons, MD
Executive Vice President
American Medical Association

"MDs fostering development of child abuse/neglect community networks . . . "

To encourage a coordinated approach to ending child abuse and neglect, the Michigan Department of Social Services is fostering the development of Child Abuse/Neglect (CAN) Community Networks across the state. These CAN Community Networks would consist of representatives of agencies now in a community working together to limit the effects of child abuse and neglect through interagency cooperation.

A number of communities have recognized the value of this coordinated approach to the problem, and have community networks in operation. These include Ann Arbor, Flint, Sault Sainte Marie, Lansing, Traverse City and Kalamazoo.

The Michigan Department of Social Services, sponsor of the task force, is hoping to encourage every community to begin and maintain its own network.

Presently, the task force is finalizing plans for a Seminar on Child Abuse and Neglect to be held Sept. 26-28 in Lansing.

The number of reported cases of abused and neglected children in Michigan has more than tripled since 1970. In 1970, there were 1,144 cases of abuse and 6,720 cases of neglect reported to authorities. Last year, that number had risen to 6,140 cases of abuse and 18,969 cases of neglect. Almost 27,000 children in Michigan during 1976 were battered, beaten, bruised, or mentally or physically neglected.

C. Vincent Anderson
Department of Social Services
300 S. Capitol Ave.
Lansing 48926

"new program . . . in management of large health care systems . . ."

The Veterans Administration has initiated a new program to prepare outstanding individuals to assume significant roles in the development and management of large health care systems.

Although the Program is sponsored by the Veterans Administration and George Washington University, it is by no means limited to VA employees. Indeed we anticipate a very rigorous national competition, and are actively seeking qualified applicants from a broad range of health and health related professions. The Program details and applicant qualifications are contained in a prospectus which we will be glad to disseminate to interested physicians.

Those with questions about the program should feel free to call me (202/389-3588).

Harrison Owen
Acting Executive Director
VA Administrative
Scholars Program
VA Department of
Medicine and Surgery
Washington, DC 20420

" . . . the MMA hopes to assure . . . care is available to all myelodysplastics."

In January 1977, the Michigan Myelodysplasia Association (MMA) formulated a coordinated team-care program for myelodysplastic patients in Michigan. Persons with myelodysplasia have problems that affect their health care, family life, socialization, schooling and life goals. The extent of these problems varies with each person and with age. Because of the multiplicity and interaction of the problems, we have found that a centralized team approach is an efficient and effective way to provide comprehensive care to these persons and their families. The team responsibilities are affected by the nature and complexities of the person's needs and the resources in the home and community.

The Division of Services to Crippled Children supports the concept that the best interests of persons with myelodysplasia are served when habilitative management is assumed by a team of professionals in the health, social and educational fields. Each team will develop channels of referral using community resources within its area for case finding, so that physicians and the families of all myelodysplasia patients will be aware of the team's availability, goals and methods. Early referral (as soon after birth as possible) to team care of all myelodysplasia children will be encouraged. The team may refer a patient to qualified professionals for treatment when the referral provides treatment more convenient or appropriate for the patient and the family. The referral will not change the team's case management responsibility.

The MMA asked its Board of Directors (representatives from the seven existing myelodysplasia clinics,* a representative from Crippled Children's and various other interested parties) to outline a coordinated care plan. The goals of the myelodysplastic team should be: 1) Assessment of each person with myelodysplasia by defining past, present and anticipated problems. 2) Establishment of individual goals for each patient. 3) Implementation and re-evaluation of a comprehensive care plan for each patient. 4) Documentation, evaluation of care outcome. The plan outlines team composition, organization, regionalization of teams, types of myelodysplasia centers, objectives of care, definition of special needs and recommended care by age level.

This plan was approved by the MMA which over the next year will concentrate on establishing a central office to evaluate and coordinate the resources of state communities, support the MMA in achieving its purposes and goals, and disseminate information on the management of myelodysplasia. In this way, the MMA hopes to assure that comprehensive care is available to all myelodysplastics.

The MMA encourages the participation of all health care and community resource personnel. The 1977 chairman of the MMA is Mason Barr, MD, University Hospital, Ann Arbor. Inquiries and requests for membership or copies of the coordinated care program should be directed to me.

E. Dennis Lyne, MD
Secretary-Treasurer, MMA
Henry Ford Hospital
2799 W. Grand Blvd.
Detroit, MI 48202

*Children's Hospital of Michigan, Henry Ford Hospital, University of Michigan, Mt. Carmel Mercy Hospital, Borgess Hospital, Wyandotte Hospital, and Mary Free Bed Hospital.

" . . . most surprised (over) evidence of insensitivity . . . (toward) SIDS."

I wish to remark on the commentary, "Physicians must show compassion for SIDS victims' families," *Michigan Medicine,* May, 1977, by John E. Smialek, MD, deputy chief medical examiner of Wayne County.

There has been a long and continuing history and dedication to the study of "crib deaths" or the sudden infant death syndrome (SIDS) in Wayne County, since 1959.

In accordance with Michigan statutes, the Medical Examiner Act Sec. 1, Act No. 181 of Public Acts of 1953 as amended, sudden unexpected deaths occurring in apparently healthy infants, without medical attention, fall under the jurisdiction of the County Medical Examiner. To exclude accident, crime or negligence, the investigation and the determination of the cause and circumstances of death are therefore vested in the medical examiner.

Because of my special interest (deputy chief medical examiner of Wayne County from 1959 to 1970), the autopsy rate on crib deaths gradually increased from less than 50% to 95% during a 10-year period. The first epidemiologic and pathologic studies of almost 1,000 cases of SIDS in Wayne County were reported, together with a prize-winning exhibit, in Chicago, in 1962[1] and in London in 1963[2]. A collaborative study with the department of epideminology, School of Public Health, University of Michigan, was published as a Ph.D. dissertation in 1963.[3] This study is even now considered the most exhaustive epidemiological study on the largest series of SIDS in space and time in the U.S. It is believed the local studies triggered a mushrooming of interest in the U.S.

There has always been excellent communication, mutual trust and understanding between the Wayne County Medical Examiner and the physicians, the department of health, police and social agencies, and the community of Wayne County. Compassionate counseling of the parents was provided during the course of the investigation, prior to and subsequent to the autopsy; also, sympathetic conversation via telephone. Informative comprehensive educational print-outs, together with a personal letter, were distributed to the parent.

However, the supportive emotional needs of the grief-stricken bereaved parents could only be partially met by the office of the medical examiner. In 1966, I assisted a group of parents to found and charter the Michigan Association of the Sudden Infant Death, Inc.[5] This later became a chapter of the National Foundation for Sudden Infant Death, Inc. Later, there was also founded a Michigan chapter of the International Guild for Infant Survival, Inc. These lay organizations, guided by a professional board, provided a unique parent-to-parent contact and a sharing of grief-in-common, which proved very effective and salutary.

It may be true that prior to the 1960's the medical profession has had meager knowledge or contact with SIDS, since the medical examiner or coroner under state statutes maintains a monopoly of SIDS cases. Occasionally, the physician may have treated the infant for a "cold," a day or two prior to demise, but was unable to explain the cause of death. On several occasions I have forestalled malpractice suits against the physician and/or emergency service. Through lectures, symposia, publications, news media, and TV, there have been increasing exposure and dissemination of information about SIDS. Therefore, I am most surprised that Doctor Smialek finds evidence of insensitivity on the part of physicians toward the grief of bereaved parents of SIDS victims.

In 1972 the National Institute of Child Health and Human Development provided funds for a nationwide study of the management of SIDS in the U.S. Interviews were conducted of 421 bereaved families. Scattered shortcomings were uncovered throughout the U.S. in dealing with prolonged grief, which could have been prevented or eased by kindly management of the family. During the summer of 1972, the writer was interviewed and questioned on two separate afternoons. Many bereaved parents were also interviewed. When the report was published in 1973,[6] many areas over the U.S. were severely criticized, but Wayne County was given a good bill of health.

As a result of the above report and the "urgency and magnitude of the 'humane' aspects of SIDS" which were brought before the hearings of the Senate Subcommittee on Children and Youth in 1972[7] and 1973,[8,9] $9 million were appropriated to be distributed as grants among 50 SIDS centers in areas of high incidence throughout the U.S. The grant titled "The Sudden Infant Death Syndrome Information and Counseling Project, Maternal and Child Health Service (DHEW) under Title XI, Public Health Service Act, 1975," was applied for, and granted to the Wayne County Medical Examiner.

Reference was made to Act No. 350 of the Public Acts of 1974 which amended the Medical Examiner Act of 1953, which authorized autopsies on SIDS at state expense, when not otherwise provided, and at the request of parents. In permitting an autopsy, not only would the parents learn the exact cause of death, but more information would be available to solve this mysterious disease, the number one cause of death in the postneonatal period. This would be a humanitarian approach! SIDS has been the acceptable cause of death since 1967.

However, it is no longer believed (by definition) that the infant is healthy, but, in fact, is now believed to be born with deficiencies or defects, and furthermore, it is now admitted that a respiratory infection may trigger the demise. Doctor Smialek recommends that SIDS be used on the death certificate, to the exclusion of other causes for the following reasons: 1. "SIDS" can be more readily recognized and, therefore, vis-a-vis acceptable for funded counseling of bereaved parents. 2. "SIDS" is more readily picked up by biostatisticians. 3. A cause of death, other than "SIDS," may aggravate the grief and guilt feeling of the parents.

This raises a very serious problem, when the pathologist, in the course of a very careful autopsy, reports either laryngo-tracheo-bronchitis or bronchiolitis, or interstitial pneumonitis, desquamative pneumonia or alveolitis, or early bronchopneumonia.[10,11] These are frequently associated with characteristics of SIDS.

Can a medical examiner act as a judge advocate and contradict such a report even though it agrees with the criteria of Averil Lebon (dean of pulmonary pathologists)? Or, can one categorically say that SIDS and a respiratory infection are mutually exclusive? And, why cannot both appear on the death certificate and thus satisfy the bereaved parents, the biostatisticians, the pathologist and/or the medical examiner?

In my many years of counseling of bereaved parents, I never have had any feed-back when I diagnosed "interstitial pneumonitis"[1,2,3] and also included "crib death" or SIDS. Moreover, an ethical problem may arise when the uninformed physician, the medical examiner, the nurse, or lay counselor in the course of counseling the bereaved parents, vehemently contradicts the diagnosis made by the pathologist, and leaves the parents confused and in limbo. Here, great tact, maturity, and *compassion* are of utmost importance!

In view of the foregoing, I feel it is incumbent upon me to bring these facts up to date.

Clara Raven, MD
Consultant Forensic Pathologist
Deputy Chief Medical Examiner
of Wayne County, Emeritus,
Retired

“. . . Gilles de la Tourette Syndrome . . .”

I can offer a packet of information about this little-known disorder of the central nervous system to all Michigan physicians who are members of your organization and would read your journal.

Because the Gilles de la Tourette Syndrome has afflicted a member of my family, I would like to help the Tourette Syndrome Association in their objective of bringing this affliction to the attention of all physicians in the nation. I know your journal could be of great assistance toward informing at least those physicians in the State of Michigan.

Sincerely,
Richard Lane
Administrator
McPherson Community
Health Center
620 Byron Road
Howell, MI 48843

“ . . . the artwork so beautifully printed . . ”

The May issue of *Michigan Medicine* was great, but particularly so because of the artwork done by Ms. Kathy Minnerly, MSMS staff, and so beautifully printed in colors for Dr. Wicks’ article.

Congratulations!

Let’s see more — it really was good, and certainly does spruce that old journal up a bit!

Sincerely,
Richard D. Coak, MD
Adrian

“. . . Lawrence Nathan is a DO and not an MD.”

I just noticed in the MSMS Journal Doctor Sander’s remarks about the Placental Registry (April *Michigan Medicine*, "letters" department). I would like to call your attention to the fact that Lawrence Nathan is a DO and not an MD. Doctor Nathan is currently a member of our pathology staff. He is a most knowledgeable and highly respected individual whose training in pathology (University of Wisconsin) is excellent.

Sincerely,
Gerald H. Mandell, MD
Associate Chairman, Sinai
Hospital Dept. of Laboratory
Medicine
Clinical Associate Professor
of Pathology, Wayne State
University College of Medicine

“I am . . . interested in time lapse between sting and death . . . ”

I am convinced that lives now needlessly lost due to severe systemic reactions to insect stings could be saved. How? By a greater awareness of the possibility of such fatal reactions plus knowledge of the existence of an insect sting kit. The kit is an emergency first aid measure to stave off anaphylaxis. Because of my convictions I am presently collecting and correlating data on the incidence of such fatalities.

I am especially interested in time lapse between sting and death although information concerning the following would be helpful: (1) time sequence of symptoms, (2) previous reactions to insect stings, (3) medication on hand at time of sting, (4) type of medication, (5) type of insect, (6) number of stings, and (7) estimation as to whether or not a physician or hospital emergency room could have been reached in time to avoid a fatal outcome.

Claude A. Frazier, MD
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Why Grand Rapids succeeds in attracting resident physicians

By Jane Haradine
Special to **Michigan Medicine**

Grand Rapids has become a magnet for physicians-in-training.

This year, the city's three MD hospitals filled all 62 first-year residency openings in the National Intern-Resident Matching Program.

That makes it the only city with a population over 100,000 in the country to have drawn 100 percent. Nationally, only 77 percent of first-year positions were filled.

In Michigan, that figure dropped to only 62 percent. Ann Arbor received 131 for 160 openings, Detroit 198 for 356, Lansing 21 for 35, Flint 13 for 44, and Pontiac seven for 43.

Cooperation succeeds

Grand Rapids' success is the result of unique change at all three hospitals in the last 10 years. "The rivalry has been turned into a constructive cooperation," says Edward L. Moorhead, II, MD, vice president of medical education, Butterworth Hospital.

When Doctor Moorhead arrived in 1967, only 12 interns were attracted for the hospital's 20 openings. Since then, Butterworth has filled every year.

"I came in identifying strongly with the house staff," says Doctor Moorhead. Another secret, explains Doctor Moorhead, is that, in considering program operation, the hospital staff always keeps an eye on recruitment. "That means, for instance," he says, "that no house staff is on call every other night. Every third night is maximum and most are on every fourth or fifth night."

Butterworth also uses a unique self-evaluation system. "The AMA comes around every four years and shakes us, but we don't wait for the AMA. Every other year, we have an in-house critique of each program to look for areas where it can be improved," he explains.

Change is encouraged. "We have to be continually on guard against complacency, the biggest problem of success," says Doctor Moorhead.

Praising the attending staff members, he says, "It's easy to attract people to a community setting where education is active. That's important. You satisfy your own need for continuing education and it's easier to do in an atmosphere where education is going on. When you're teaching, you're also being taught."

Board score results of physicians completing the Butterworth programs are excellent, Doctor Moorhead says, "comparable with university board scores and in the top 10 to 25 per cent nationally where scores are given (for comparison)."

GRAMEC formed

Another big stimulus in recruitment was the arrival of MSU students in 1966 for a short-term experience and development of a Grand Rapids campus for MSU in 1976 to provide the final year of undergraduate work for the medical students.

A city-wide educational organization that had existed only as a dream for the MSU affiliation was born with the push of outside dollars. A family practice program was being considered by Blodgett and St.

Mary's. Funding had been requested from the Kellogg Foundation.

The foundation agreed to give the money, but only to a citywide corporation. The Grand Rapids Area Medical Education Center (GRAMEC) was formed in November, 1971. Four months later, family practice was started. Now there are 24 residents in the three-year program that utilizes all three hospitals. GRAMEC since has added residencies in pathology and radiology, also.

Through all this, Blodgett has maintained the most stable program. 1967 was the last year when intern slots were not filled there. But Blodgett's program was small. In internal medicine, there were only four residents. The combined program with St. Mary's now has 22 in the second and third years. The lack of a pediatrics residency was solved through a link with Butterworth. There now are 11 pediatrics residents, eight of them in the final two years.

Blodgett hired a full-time director of medical education, Robert L. Tupper, MD, in 1973. Doctor Tupper's only other responsibility is supervision of the medical clinic.

All three directors of medical education are young enough to be open for change and run with that fine mix of pride in their own institution and an openness that encourages cooperation.

As evidence of this cooperation, the 206 house staff members in the city are listed on a single roster this year for the first time.

St. Mary's complements

The Grand Rapids hospital that suffered the most in past competition for interns was St. Mary's. Long known for its general practice program, St. Mary's was hit 15 years ago by the changeover to specialization. And clashes with interns went unresolved.

John C. Peirce, MD, director of medical education, said the hospital didn't get one intern in 1962. He was hired in 1963.

"I realized that St. Mary's was going to have to get involved in the primary care specialties," Doctor Peirce said. The only strong programs the hospital had were in orthopedic surgery and general surgery.

Without a pediatrics base and the necessary depth for internal medicine, he decided to "try to develop a program to complement the other two hospitals, to try to woo a combined residency."

His own field of nephrology became the first sub-specialty in internal medicine. Pulmonary disease was the second developed. Later others were added in endocrinology, hematology and rheumatology.

Internal medicine residents at both Butterworth and Blodgett hospitals has been completing their training in other cities where they could gain experience in the sub-specialties. In the late 1960's, that changed, and residents started rotating through St. Mary's for this experience.

Programs combine

There now are nine combined programs. "What we basically did was open up the city and use the strengths, irrespective," Doctor Peirce said. Blodgett is linked to St. Mary's in two combined programs and to Butterworth in two. All three hospitals share residents in four programs and one is psychiatry links Michigan State University with Pine Rest Christian Hospital.

Grand Rapids attracts

The prime attraction to Grand Rapids, according to the new house staff members, is the excellent reputation the hospitals have for quality care and the dedication of the medical staffs for teaching. When they visit the hospitals as seniors, they hear no serious rumblings from their predecessors.

But the one advantage all three hospitals have for which they can take no credit is Grand Rapids, the city.

James D. Green, MD, University of Illinois graduate, said, "After four years in Chicago, I had had it with a large metropolitan environment. Grand Rapids is ideal. It's not a small community, but there's less paranoia about crimes. No triple locks on doors.

"When medical students start looking, they consider the type of community they want to be practicing in, and Grand Rapids is that kind of place," he said. Doctor Green is starting an internal medicine residency.

Another important plus comes from the friendly attitude the prospective residents notice on their first visits.

Carl F. Kolbe, MD, Wayne State University graduate, noted a striking difference in Grand Rapids from other places he visited. "It was the only place where the residents really enjoyed working. They worked hard and had a lot of patients, but they had fun while they worked."

Steven E. Ottenweller, MD, from Indiana University, who just completed his fifth year in Butterworth's surgery program, confirmed the impression: "The medical community is friendly, not impersonal at all. You're on a first-name basis."

Curt L. Keller, MD, a graduate of the University of Kentucky starting obstetrics and gynecology, said he had planned to stay in Kentucky, but changed his mind after a trip to Blodgett "just to satisfy myself. I never heard a bad thing about it. At other hospitals, they always said, 'The program is improving.' "

Recruiting costs

Recruiting costs at the three hospitals totaled $28,500 last year, with all paid by the attending staffs. Butterworth spent $14,000, Blodgett $10,000 and St. Mary's $4,500.

The recruitment efforts are similar, with information sent to the hundreds who inquire. Visits to the city are encouraged.

An annual senior week-end in October is a coordinated hospital function, the one time when the entire medical community turns out.

The process already has started for next year. The three educational chiefs report inquiries are way ahead of last year at this time. "It's alarming," said Doctor Tupper, "but a happy alarm."

Category I Courses

Michigan Medicine *each month will carry a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of the new Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing will indicate a contact person, so the physician can obtain details. The list will be expanded as courses are developed by accredited sponsors. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351.*

Date: Aug. 13-14, **AMA Regional CME Program. Location:** Northern Michigan University, Don Bottom Conference Center, Marquette. **Sponsor:** American Medical Association. **For:** All specialties. **Cost:** Prices for five courses, $70; Advanced CPR, $160. **Contact:** Gale Jewitt, AMA, (312) 751-6570. **Approved for:** 6 hours of Category I credit, 14 for advanced CPR.

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Date: August 26-29, Advances in Management of Infectious Diseases; Location: Mackinaw Island; **Sponsor:** Office of Continuing Education, Department of PGM/HPE; **For:** All interested physicians; **Cost:** $150; **Contact:** U of M Office of Continuing Education;* **Approved for:** 11 hours of Category I Credit.

* * *

Date: Sept. 1-2 — **1977 Harold C. Mack Symposium on the Physiology and Pathology of Reproduction, "Controversies in Contraception." Location:** Michigan Inn, Southfield. **Sponsor:** Department of Gynecology and Obstetrics, WSU. **Co-Sponsor:** C. S. Mott Center for Human Growth and Development, Searle Lab. **For:** Gynecologists and Obstetricians. **Cost:** $75. **Contact:** Kamran S. Moghissi, MD, C. S. Mott Center for Human Growth and Development, 275 East Hancock, Detroit 48201. **Approved for:** 14 hours of Category I Credit

* * *

Date: Sept. 7, **"Renal Problems for the Practicing Physician." Location:** Kalamazoo Hilton. **Sponsor:** Michigan Nephrology. **Co-sponsor:** SMAHEC. **For:** All interested physicians. **Cost:** None. **Contact:** Jeff Block MD, Michigan Nephrology, 1521 Gull Road, Kalamazoo, 49001. **Approved for:** 7 hours of Category I credit.

* * *

Date: Sept. 14-17, **International Conference on Red Cell Metabolism and Function; Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor; **Sponsor:** Office of Continuing Education, Department of PGM/HPE, U of M Medical Center; **For:** Hematologists, Internists, blood banking specialists; **Cost:** $100; **Contact:** G. J. Brewer, MD, Dept. of Human Genetics, Univ. of Michigan Medical School, Ann Arbor 48109; **Approved for:** 20 hours of Category I Credit.

Date: Sept. 16-18 — **A Practical Course in Diagnostic Ultrasound. Location:** Towsley Center, U of M Medical Center, Ann Arbor. **Sponsor:** U. of M Office of Continuing Education, Dept. of PGM/HPE. **Cost:** $125. **Contact:** Floyd C. Pennington, Ph.D., Director, U-M Office of Continuing Education.* **Approved for:** 16 hours of Category I Credit.

* * *

Date: Sept. 21, **"What's New in Hyperalimentation — Parenteral, Enteral." Location:** Kalamazoo Hilton. **Sponsor:** SMAHEC Family Medicine programs. **Cost:** $35. **Contact:** Donald E. DeWitt, MD, Coordinator, Family Medicine Residency, SMAHEC, 252 E. Lovell St., Kalamazoo, 49006. **For:** All interested physicians. **Approved for:** 7 hours of Category I credit.

* * *

Date: Sept. 26-27, **Accreditation and Conduct of Community Hospital Based CME; Location:** Holiday Inn, Mt. Pleasant; **Sponsor:** Office of Continuing Education, Department of PGM/HPE, U of M Medical Center; **Co-Sponsor:** Michigan Hospital Association and the MSMS Commission on Continuing Medical Education; **For:** All interested physicians and educators; **Contact:** Susan Wright, Program Coordinator, 313/763-0200. **Approved for:** 8½ hours of Category I Credit.

* * *

Date: Sept. 29-30, **"Non-invasive Diagnostic Techniques in Cardiovascular Disease." Location:** Borgess Hospital, Kalamazoo. **Sponsor:** Cardio-Vascular Services, Borgess. **Co-sponsor:** SMAHEC. **For:** All interested physicians. **Cost:** None. **Contact:** Robin K. Norbe, Cardiovascular Services, Borgess Hospital, 1521 Gull Road, Kalamazoo, 49001. **Approved for:** 10 hours of Category I credit.

* * *

Date: Oct. 8, **Clinical Day on "Low Back Pain." Location:** Inservice Classrooms, Holy Cross Hospital, 4777 E. Outer Drive, Detroit. **Sponsor:** Holy Cross Hospital Medical Staff Education Committee. **For:** All specialities. **Cost:** $25. **Contact:** Kenneth K. Newton, M.D., Director of Medical Education, (313) 369-9100, ext. 2355. **Approved for:** 6 hours of Category I Credit.

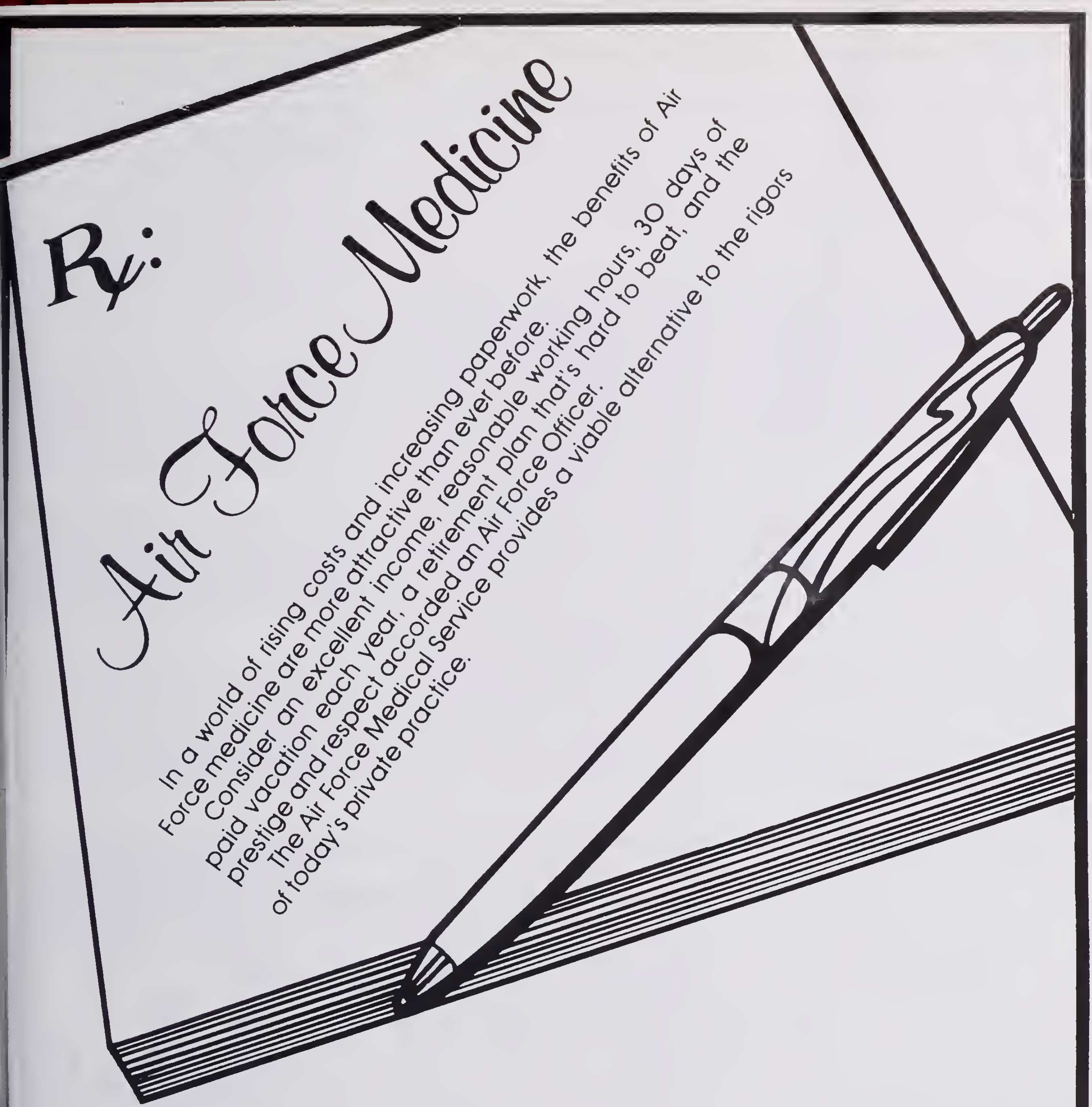
* * *

Date: October 12, **Diseases of the Breast. Location:** St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **Cost:** $50. **Contact:** Department of CME, St. John Hospital, (313) 881-8200, ext. 321. **Approved for:** 7 hours of Category I Credit.

* * *

Date: Oct. 22, **"Manifestations of Systemic Diseases in Sub-Specialties." Location:** Inservice Classrooms, Holy

(Continued on page 438)



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Cross Hospital, 4777 E. Outer Drive, Detroit. **Sponsor:** Holy Cross Hospital Medical Staff Education Committee. **For:** All specialties. **Cost:** $25 for staff members; $35 for non-staff members. **Contact:** Kenneth K. Newton, MD, Director of Medical Education, (313) 369-9100, ext. 2355. **Approved for:** 6 hours of Category I Credit.

Date: Nov. 2, "Current Therapy of Infectious Disease." Location: Kalamazoo Hilton Inn. **Sponsor:** Michigan Academy of Family Physicians. **Co-sponsor:** SMAHEC. **For:** All interested physicians. **Cost:** None. **Contact:** Joe Alberding, Portage Medical Clinic, P.C., 225 E. Centre St., Portage 49081. **Approved for:** 7 hours of Category I credit.

Date: Nov. 3-4, "Progress in Cardiology." Location: Borgess Hospital, Kalamazoo. **Sponsor:** Borgess Cardiology Dept. **Co-sponsor:** SMAHEC. **For:** All interested physicians. **Cost:** None. **Contact:** Robin K. Norbe, Cardiovascular Services, Borgess Hospital, 1521 Gull Road, Kalamazoo, 49001. **Approved for:** 10 hours of Category I credit.

Date: Nov. 4-5, Twenty-Fifth Annual Symposium on Trauma; Location: Harper Hospital, Second Floor Webber Wing, 3990 John R, Detroit; **Sponsor:** Michigan Committee on Trauma of the American College of Surgeons; **Co-Sponsor:** Wayne State University Department of Surgery; **For:** All interested physicians; **Contact:** Joseph L. Posch, MD, Chairman, 1408 Kales Building, Detroit, 48226, Ph: (313) 962-0727; **Approved for:** 9 hours of Category I Credit.

Date: November 8-10, MSMS Annual Scientific Session. Location: Hyatt Regency Dearborn. **Sponsor:** MSMS Committee on CME Programming. **For:** All specialties. **Contact:** Herbert Auer, MSMS Department of CME Programming. (517) 337-1351.

Date: Nov. 16 — Diseases of the Biliary Tract. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** All specialties. **Contact:** Department of CME, St. John Hospital, Detroit (313) 881-8200, ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 26-30 — Ophthalmology Review. Location: Dearborn Inn. **Sponsor:** WSU-Department of Ophthalmology. **For:** Ophthalmologists. **Cost:** $350. **Contact:** WSU Division of CME, Room 1209 Scott Hall, 540 East Canfield, Detroit 48201. **Approved for:** 40 hours of Category I Credit.

Date: Dec. 10 — "Needle Aspirations" Seminar. Location: University of Michigan, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** John F. Dunkel, MD, Department of Pathology, Michigan State University, East Lansing 48823 or James W. Landers, MD, Department of Pathology, St. John Hospital, Detroit. **Approved for:** 3 hours of Category I Credit.

Continuing Courses

Date: Continuing Quarterly Journal Club — Surgery; Location: Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Surgeons; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Monthly, Cleft Palate Clinic. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital****. **For:** Oral Surgeons, plastic surgeons, pediatricians. **Cost:** None. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 3 hours of Category I Credit.

The following have been accredited directly by the AMA or by MSMS Commission on Continuing Medical Education:

Organizations:

- Ann Arbor Psychiatric Association
- Michigan Academy of Family Physicians
- Michigan Academy of Plastic Surgery
- Michigan State Medical Society
- Michigan Chapter, American Academy of Pediatrics
- Michigan Dermatological Society
- Michigan Heart Association
- Michigan Lung Association, Lansing
- Michigan Society of Anesthesiologists
- University of Michigan School of Public Health

Hospitals:

- Alma-Gratiot Community Hospitals, Alma
- William Beaumont Hospital, Royal Oak
- Beyer Memorial Hospital, Ypsilanti
- Blodgett Memorial Hospital, Grand Rapids
- Bon Secours Hospital, Grosse Pointe
- Burns Clinic Med.Center, PC/Little Traverse Hospital, Petoskey
- Butterworth Hospital, Grand Rapids
- Central Michigan Community Hospital, Mt. Pleasant
- Community Health Center of Branch County, Coldwater
- Community Hospital Association of Battle Creek
- Detroit-Macomb Hospital Association
- Ferguson-Droste-Ferguson Hospital, Grand Rapids
- Grace Hospital, Detroit
- Henry Ford Hospital, Detroit
- Holy Cross Hospital, Detroit
- Hurley Medical Center, Flint
- Ingham Medical Center, Lansing
- Kalamazoo State Hospital
- Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital), Muskegon
- Marquette General Hospital
- McLaren General Hospital, Flint
- Mercy Hospital, Port Huron
- Mt. Carmel Mercy Hospital & Med. Center, Detroit
- Munson Medical Center, Traverse City
- North Detroit General Hospital, Detroit
- Oakland Medical Center, Pontiac
- Oakwood Hospital, Dearborn
- Pontiac General Hospital, Pontiac
- Port Huron Hospital CME Committee
- Providence Hospital, Saginaw
- Saginaw Cooperative Hospitals Inc., Saginaw
- Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
- St. Francis Hospital, Escanaba
- St. John Hospital, Detroit
- St. Joseph Hospital, Flint
- St. Joseph Mercy Hospital, Pontiac
- St. Joseph Mercy Hospital, Ann Arbor
- St. Lawrence Hospital, Lansing
- St. Mary's Hospital, Grand Rapids
- St. Mary Hospital, Livonia
- Sinai Hospital of Detroit, Detroit
- Edward Sparrow Hospital, Lansing
- Traverse City State Hospital, Traverse City
- V. A. Hospital, Battle Creek
- Wayne County Psychiatric Hospital, Eloise
- West Shore Hospital, Manistee
- Ypsilanti State Hospital, Ypsilanti

Date: **Monthly, Tissue Audit (Cancer).** **Location:** Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Surgeons, ob-gyns, pathology, radiology. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 2 hours per session Category I Credit.

Date: **Monthly Lecture Series in Ophthalmology;** **Location:** Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Ophthalmogists; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: **Monthly, Ob/Gyn Journal Club.** **Location:** Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** All interested physicians. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: **Monthly Urology Journal Club;** **Location:** Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Urologists; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital****; **Approved for:** 2 hours of Category I Credit.

Date: **Begins September, Continuing Training in Family Therapy.** **Location:** Suite 1212, North Park Plaza, 17117 W. Nine Mile Road, Southfield. **Sponsor:** Family Institute of Southeastern Michigan. **Co-sponsor:** Ackerman Institute. **For:** Psychotherapists. **Cost:** Varies according to time put in. **Contact:** Carolyn R. Tourkow, MSW, director, Family Institute of Southeastern Michigan. **Approved for:** Hours vary with time spent.

Date: **Every Tuesday — Psychiatry — Special Problems Seminar;** **Location:** Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Psychiatrists; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital****; **Approved for:** 2 hours of Category I Credit.

Date: **Every Tuesday morning, Gynecology/Obstetrics Combined Grand Rounds.** **Location:** Jackson Auditorium, Hutzel Hospital. **Sponsor:** Wayne State University Department of Gynecology-Obstetrics. **For:** All interested physicians. **Cost:** No charge. **Contact:** Wayne State University, Division of CME**. **Approved for:** 4 hours each of Category I Credit.

Date: **Wednesdays, Sept. 14 - Nov. 16, Cardiology Seminars.** **Location:** St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** All specialties. **Cost:** $200. **Contact:** Department of CME, St. John Hospital, (313)881-8200, ext. 321. **Approved For:** 2 hrs per session hours of Category I Credit.

---

*Office of Intramural Education, University of Michigan Medical Center, Dep't. of PGM/HPE, Ann Arbor, 48109

**WSU Division of CME, Room 1209, Scott Hall, 540 E. Canfield, Detroit, 48201 (313) 577-1453

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902

****Department of CME, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 272-6000

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In Memoriam

Robert F. Allen, MD
Petoskey

Radiologist Robert F. Allen, MD, Petoskey, died at age 66 on April 28. Doctor Allen was a graduate of Temple University Medical School in Pennsylvania. He was affiliated with Lockwood-MacDonald Hospital, Petoskey; Cheboygan Community Hospital, and Rogers City Hospital. Doctor Allen was past president of Northern Michigan Medical Society.

John G. Arent, Sr., MD
Detroit

John G. Arent, Sr., MD, of Detroit, died June 10 at the age of 71. Doctor Arent, a graduate of Tufts University Medical School, Boston, was on the staff of Mt. Carmel Mercy Hospital and Brent Hospital for 25 years.

John A. Cowan, MD
East Lansing

Well-known health official, John A. Cowan, MD, of East Lansing, died June 30 at the age of 73. A University of Minnesota Medical School graduate, Doctor Cowan was a public health department physician for 23 years. Doctor Cowan, a consultant to the U. S. Public Health Service, was nationally recognized in the venereal disease control field.

Carl A. Gardner, MD
Kalamazoo

Carl A. Gardner, MD, Kalamazoo otolaryngologist, died June 28 at the age of 54. Doctor Gardner was a graduate of Syracuse University College of Medicine in New York and was affiliated with Bronson Methodist and Borgess hospitals, both in Kalamazoo.

John W. Kavanaugh, MD
Kalamazoo

John W. Kavanaugh, MD, a specialist in obstetrics and gynecology, died May 31 at the age of 53. Doctor Kavanaugh, of Kalamazoo, was a graduate of Stritch School of Medicine in Illinois. He was affiliated with Borgess and Bronson hospitals.

Mandell Lansky, MD
Detroit

Mandell Lansky, MD, Detroit, died June 19 at the age of 59. Doctor Lansky was a graduate of Wayne State University School of Medicine and was a specialist in internal medicine. He was on the staff of Deaconess Hospital, Detroit, and was a captain in the Army Medical Corps in World War II.

Myron H. Miller, MD
Royal Oak

Myron H. Miller, MD, 81, of Royal Oak, died June 4. Doctor Miller, a Detroit physician for more than 50 years, served on the staff of Providence and Mt. Carmel-Mercy hospitals. He graduated from the University of Illinois College of Medicine.

Archibald C. Pfeifer, MD
Miami

Archibald C. Pfeifer, MD, Miami, Florida, died June 27 at 86. A specialist in proctology, Doctor Pfeifer graduated from the University of Michigan Medical School. He was past president and former bulletin editor of Genesee County Medical Society and his membership in specialty societies included American Proctologic Society and Flint Academy of Surgery. Doctor Pfeifer served in the Navy during World War I.

Harvey V. Sparks, MD
Flint

Harvey V. Sparks, MD, died June 27 at the age of 62. Doctor Sparks, of Flint, was a specialist in internal medicine. He was a graduate of the University of Michigan Medical School and was affiliated with McLaren General, Hurley, and St. Joseph hospitals, all of Flint. He was a member of the American College of Physicians and the American Geriatric Society.

Elisha John Tamblyn, MD
Detroit

Elisha John Tamblyn, MD, Detroit, former chief of staff at Bon Secours Hospital, Grosse Pointe, died June 12 at age 90. Doctor Tamblyn was also on the staff at Cottage Hospital of Grosse Pointe Farms.

Verne L. VanDuzen, MD
Milan

Verne L. VanDuzen, MD, Milan, died June 6 at 81. A graduate of the University of Michigan Medical School, Doctor VanDuzen served on the staff of the Ypsilanti State Hospital before his retirement. Doctor VanDuzen was a psychiatrist and held memberships in the Michigan Geriatric Society and the Michigan Society of Psychiatry and Neurology.

Arthur P. Wilkinson, MD
Bloomfield Hills

Retired physician Arthur P. Wilkinson, MD, formerly of Bloomfield Hills, died June 16 at the age of 81. Doctor Wilkinson, a specialist in ophthalmology and otolaryngology, was formerly chief of the eye, ear and throat department at Women's Hospital, Detroit. He was a graduate of Johns Hopkins University, and was an Air Corps veteran of World Wars I and II. He was certified by the American Board of Ophthalmology and Otolaryngology and was a member of the American College of Surgeons.

Classified

DIRECTOR OF MEDICAL EDUCATION — Seeking a board certified or board eligible physician, preferably in a primary care discipline and with teaching experience, for a recently formed educational corporation with three hospital members, totaling approximately 520 beds. Excellent salary and benefits. Position available immediately. Please send curriculum vitae, or call A. M. Moeller, MD, President, Bay County Medical Education, 100 Fifteenth Street, Bay City, Michigan 48706, 517/893-5271.

FOR SALE a relatively new, nice medical building, fully equipped for medical practice. Down payment is very reasonable and sale would be by land contract. The Doctor who has had excellent practice for 17 years retired due to poor health. If interested call 1-517-592-2124 or 1-517-592-5165.

INTERNIST/FAMILY PHYSICIAN. Applicant must be interested in general family medicine for four integrated clinics in city and suburbs. Complete laboratory and nuclear medicine. Foreign graduates must have state license. Liberal salary. Call or write Trail Clinic, PC, Cindy Papuga, Clinic secretary. (313) 861-4400, 18254 Livernois, Detroit 48221.

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PHYSICIAN — DIRECTOR needed for Jackson Medical Center, Inc., a non-profit clinic providing medical care for patients in need regardless of ability to pay. A permanent position with very attractive salary (approximately $50,000), 40-hour work week, no weekends, no nights, no hospital duty. Excellent recreational area in rolling farm country with city population of 50,000. Prefer internist or family physician. Contact F. S. Korotney, M.D., 720 W. Franklin, Jackson, 49201.

POSITIONS AVAILABLE. For the Lansing office, two internists and one Psychiatrist — For Traverse City, a part time or full time Internist — and for Oak Park, one Internist and possibly one Psychiatrist, — These physicians to be with the Disability Determination Program under Social Security Administration. Salary currently in high thirty thousands, plus 22% fringe benefits, including life, accident, long term disability and hospital and major medical coverage. An outstanding benefit is deferred compensation. Pension benefit after 10 years' service. Liability insurance not necessary. 40 hour work week. No weekends or nights. 50 hours allowed for obtaining necessary CME credits. Vacation leave and sick leave is given. Position entails review of medical records, training and teaching of disability examiners, as well as some public relations. An equal opportunity employer. All enquiries treated confidentially. For further details, please write: Disability Determination Program, Box 30011, Lansing, Michigan 48909, OR call collect: Harry D. Nesmith, M.D., Chief Review Physician, (517) 373-7789.

ATTRACTIVE OFFICE SPACES now available for rent in the Muskegon Mall area. Located in the Medical Arts Plaza, 315 West Clay Avenue, Muskegon, Michigan. Reasonable rates with many modern conveniences. For further information please contact Mrs. Westerman, (616) 726-3641 or after 5:00 p.m. (616) 725-7120.

WANTED: Staff physician, Michigan license required, for 350-bed fully accredited hospital for the care of rehabilitation, tuberculosis, psychiatric and chronic disease patients. 40 hours week. Excellent salary and fringe benefits. Contact: Personnel Director, Saginaw Community Hospital, 3340 Hospital Road, Saginaw, Michigan 48605.

PEDIATRICIAN — BOARD CERTIFIED: Solo practitioner desires associate for practice in Southeastern Michigan near Downriver Area. Terms negotiable. Send replies to MSMS, 120 W. Saginaw, Box 3, East Lansing, MI 48823.

PHYSICIANS ASSISTANT — Graduates from Western Michigan University August 1977 with B.S. degree in medicine, AMA approved. Seeks small group or solo practitioner that could utilize a P.A. B.S. University of Wisconsin, four years experienced corpsman in the U.S.N. Write or call Donald Faulkner, 1605 W. North Street, Kalamazoo, MI, 49007, 616/349-2705.

METAL PLAQUE — Honorary certificates, diplomas, photos, etc, perfectly reproduced in bright silver toned metal with black lettering, all the clarity of the original yet immune to deterioration. Mounted on richly finished walnut base 10 × 12 for only $39.95. Allow three weeks. Perma-Plaque, 778 Rivard, Grosse Pointe, Michigan, 48230, 313/884-9399.

PHYSICIAN NEEDED — in new DeWitt township medical-dental building. Medical site 1,120 square feet. Very reasonable rent. Close to all Lansing hospitals. Call 517/669-3220 (office) or 517/349-2914 (home, after 5:00).

WANTED: Family physician. Join group practice. Salary $48,000. Early partnership possible. Located Sterling Heights, Michigan. Call collect 313/939-9160.

PSYCHIATRIST wanted. MD or DO, in Detroit area to supervise mental health team. Send resume and salary requirements to Michigan State Medical Society, 120 W. Saginaw, Box 4, East Lansing, MI 48823. Confidentiality maintained.

ORTHOPEDIC SURGEON AND INTERNIST needed for industrial medical clinic. Full or part-time. Good working conditions. No malpractice worries. Metro Industrial Clinic, 7845 Middlebelt, Romulus, MI 48174, 313/326-0800.

PSYCHIATRIST-BOARD ELIGIBLE OR BOARD CERTIFIED — wanted for full-time employment as Medical Director in a community Mental Health Center serving a four-county population of approximately 60,000.

In addition to regular psychotherapy and medical responsibilities, this position requires the coordination and supervision of treatment programs of the Center.

We are located in Michigan's beautiful Upper Peninsula Copper Country, consisting of small communities and surrounded by excellent outdoor recreational facilities.

The Center is certified by the Michigan Department of Mental Health and is funded primarily by State and local governmental monies.

Salary negotiable. All applicants must have or be eligible for a Michigan Medical license. Contact: Earl F. Ex, C. S. W. Director, Copper Country Mental Health Center, P. O. Box 47, Houghton, MI, 49931, 906/482-2212.

ORTHOPEDIC SURGEON: Board Certified or eligible, name your terms and guarantee. Northern Michigan resort area of 60,000 population. Contact D. L. Patterson, 2225 E. Randol Mill Road, Suite 321, Arlington, Texas 76011, phone 817/227-6437.

OFFICE FOR RENT in community greatly needing family physician. Office available as of June 30. Completely remodeled in late 1975. Centrally located, ample parking space. Can be rented as is. Fully equipped for practice. Please contact Frederick B. Williamson, MD, 922 Pleasant Drive, Ypsilanti, 48197.

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PRACTICE FOR SALE in a small town 20 minutes drive from University of Michigan Medical Center Family Practice, same location for over 40 years. Good gross income with minimal rent and low overhead. Office fully equipped with furniture, X-ray, lab, minor surgery set up, cautery and EKG. Call 313/761-2289 or write to A. Abraham, 1960 Traver Knoll, #208, Ann Arbor, Michigan 48105.

EXCELLENT OPPORTUNITY FOR PRACTICE in the small community of Mason south of Michigan State University. 1000 feet of new office space is available with Mason General Hospital within 100 yards. Building is ranch-type, landscaped, with large, paved parking lot. Write Dr. Douglas Gray, 230 S. Temple Street, Mason, Michigan 48854.

FAMILY PRACTICE/GENERAL PRACTICE: If you want to step into an existing solo, possible partnership, practice netting approximately $75,000 per year with no capital investment, in Michigan's Upper Peninsula, please contact Michael Drobot, Administrator, Menominee County Lloyd Hospital, 1110 Tenth Ave., Menominee, Michigan 49858. Phone 906/863-5571.

MEDICAL OFFICE SUITE — All new medical center in prime location of Brighton. 1350 square feet, four exam rooms, private office and entrance, laboratory, excellent parking, ideal to accommodate one or two doctors. Immediate occupancy. Call Davis Professional Building 313/229-2752 or 313/229-7525.

FULL-TIME ASSOCIATE DIRECTOR — Position of Assistant or Associate Director available to fill 3rd full-time faculty position in well established 9-year old Family Practice Residency program in Mid-Michigan.

Faculty appointment and affiliation with Michigan State University College of Human Medicine available. Salary commensurate with training and experience, excellent fringe package.

Strong point of this community based program is its excellent community involvement of Family Physicians and traditional specialists dedicated to a teaching program. Soon moving to all new ambulatory care center.

Should be Board Certified. Full complement of 24 residents. Duties would be resident and 3rd and 4th year medical students teaching and supervision. Minimal administrative duties.

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Contact: Robert J. Toteff, MD, Director, Family Practice Residency, 705 Cooper Street, Saginaw, Michigan 48602.

Joint practice conference Oct. 7-8

On Oct. 7 and 8, physicians and others with an interest in joint practice, may learn more about this concept in actual practice settings. Key executives also will discuss health care cost implications at a 10-state regional joint practice conference at the Hyatt Regency Dearborn being planned by the Michigan Joint Practice Commission (MJPC). The workshop will be funded in part by a grant from the National Joint Practice Commission.

The MJPC includes representatives from MSMS, the Michigan Nurses Association and the Michigan Pharmacists Association.

In the opening session Friday afternoon speakers will discuss "Health Care Costs: Who Pays?" Speakers will include John McCabe, president, Blue Cross/Blue Shield of Michigan; Melvin Glasser, director, Social Service Dept., UAW International; and Victor Zink, a General Motors vice president.

The evening dinner speaker will be a high-ranking government official.

On Saturday, Harold Gardner, MD, MSMS member of the Michigan Joint Practice Commission, will speak on "Primary Care-Health Care Delivery Model." Doctor Gardner, executive director, Health Care Institute, Detroit Medical Center and Wayne State University, was formerly head of a successful joint practice model in Rochester, New York.

A joint practice team from Minnesota will deal with "Establishing Joint Practice Privileges in the Hospital" while the Saturday luncheon will feature "How Can the Clinical Pharmacist Contribute to the Health Care Team?" Larry Swanson, assistant dean of administration & student affairs, WSU College of Pharmacy and Allied Health Professions, will be the speaker.

Following lunch, a University of Iowa physician, nurse and pharmacist will describe a model for "Joint Practice in a Family Practice Setting."

Cost of attending the conference is $60 which includes the Friday evening dinner and the Saturday luncheon.

Category I CME credit for physicians attending is being applied for.

Physician members of the MJPC include: H. Richard Henderson, MD, chairman; Roy Gerard, MD; Harold Gardner, MD, Carolyn Creighton, MD, and Louis R. Zako, MD.

Watch for a registration blank in future issues of *Medigram*. Physicians wishing further details may contact Mert Scholten at MSMS headquarters.

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Potpourri

By Herbert A. Auer, Executive Editor

One of the new groups really caught up in the swirl of rising costs are the publishers of magazines. One of the *Time* magazine officials recently declared "We're guilty of raising several generations of people who believe that magazines should be sold for 10 cents." *Time* and *Newsweek* recently raised their subscription prices 86 percent, and *Reader's Digest* kicked the newsstand price up 50 percent. Both news magazines sell now for $1 per copy. Inflation is the culprit. Newspapers are following suit.

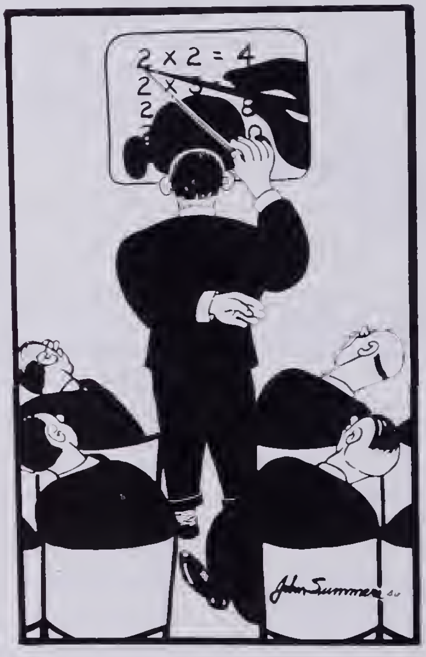
* * *

Programs of consumer education must be designed to inform the public that new medical technology almost invariably means higher medical costs," declares Howard H. Hiatt, MD, dean of the Harvard School of Public Health. Dean Hiatt observes that "some technologies will be so costly in relation to benefits that society will be forced to renounce or limit them."

* * *

Journalist Bill Moyers recently declared at a college assembly: "Part of our frustration grows out of the complexity of the modern world. New advances in weapons, warfare, communication, and transportation; in methods of production, and computer technology, and medicine; in agriculture have changed familiar institutions, work habits, and human relationships until it is no longer possible for each of us to know what society expects of us and how we relate to the whole."

Physicians and medical organizations can open many doors for newspapers which today are looking for more warm, human-interest articles. "Papers should run more illustrated features," declares H. L. Stevenson, UPI editor-in-chief in an interview in *Editor and Publisher.*



One of the pet peeves at medical meetings is shown in the cartoon above, which is one of the illustrations in an article by Conrad R. Lam, MD, Detroit, which was published in the *Review of Surgery.* Doctor Lam, in his article entitled "Speaking before Medical Groups" observes that "A speaker before a group is really carrying on a conversation with each person in the group." Lots of good advice there in one sentence.

"MSMS must have issues in addition to those that affect the professional life of physicians," so observes State Senator Earl Nelson, of Lansing.

* * *

A respected actuary estimates that "if the recent trend of increasing malpractice suits and awards continues, the price tag for malpractice in 25 years will equal the gross national product."

* * *

The famed American jurist, Judge Learned Hand, once wrote, "The First Amendment presupposes that right conclusions are more likely to be gathered out of a multitude of tongues, than through any kind of authoritative selection. To many this is, and always will be, folly, but we have staked upon it our all."

* * *

"To paraphrase Shakespeare, the good that business does is often buried in their annual reports, their mishaps crop up on the evening news, on the front pages, and between the covers of books." — R. Manning Brown, Jr., chairman of the board of the New York Life Insurance Company.

* * *

"My idea of an agreeable person is a person who agrees with me," so said Benjamin Disraeli.

* * *

In commenting on an AMA membership recruitment message that appeared recently in *Michigan Medicine,* one of the executives at the AMA thanked MSMS for its "invaluable support" and added, "We realize that your journal is among the best-read medical publications of your physician members."

* * *

The Michigan Documents Library collected 6,036 items published by state government last year, July 1975 — June 1976. About 671 of those are considered major publications and are available through public libraries.

Michigan Medicine Contents

***Michigan Medicine*, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about contemporary issues and actions of the Michigan State Medical Society, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.**

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The Publication Committee of the MSMS Council is the editorial board of *Michigan Medicine* and advises the Council and the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

In the next issue . . .

MSMS leaders discuss their views of Blues' new reimbursement programs.

President's Page

Vernon V. Bass, MD
MSMS President

Legislature, MSMS and AMA easing medical liability problem

Medical liability is still our number one problem, though great strides have been made in all areas.

Medical liability is a people problem: the courts, judges, juries and public are beginning to see that capricious, unrealistic awards to undeserving plaintiffs promote higher medical bills and higher hospital, doctor and pharmaceutical insurance. Health insurance costs increase not only because of direct costs, but also because of necessary defensive medicine.

The legislature, the AMA and MSMS have worked hard on the liability insurance problem. The legislature is attempting to define malpractice as opposed to maloccurence. This would bring about justice with settlements based on merit, not on maloccurrence or recompense for an unavoidable or unknown result.

When availability of insurance became an immediate problem, the Michigan legislature established the Brown-McNeely Fund as a temporary solution to the availability problem.

The AMA has viewed the solution to medical liability as a state problem. It offers assistance and counsel as to model laws and tort reform. The AMA established AMACO (a medical liability company) to assist state insurance companies and to provide an entry into the reinsurance market.

Your MSMS, cognitive of the problem for over 10 years, first offered legislative solutions that were ignored as not urgent. We established liaison with the Michigan Bar Association. Insurance committees of your society studied the situation.

Upon recommendation of your Insurance Committee, approval by the MSMS House of Delegates and ratification by the Council that the climate was right, Michigan Physicians Mutual Liability Company was formed. MPMLC now insures over 1,700 MDs and DOs, offers a $200,000/600,000 policy limit, has over $5½ million in surplus, over $13 million in assets, is a safe, reliable and responsive company. It is fully controlled by a board of directors, all physicians who are elected by the policyholders. MPMLC has introduced innovations tailoring the risk to premium by territorial area, using a new eight-class schedule to more adequately assess individual physicians' risks, practicing stringent underwriting, reducing to half the premiums required of new physicians in Michigan, thus encouraging an increase in our physician population.

The MPMLC Board now feels it can direct its attention to those ideas it was formed for: risk management, re-evaluation of its classification schedule and, hopefully, prudently reducing premiums.

(See related articles, pages 455-456)

When impotence due to androgenic deficiency is driving them apart

Android®-5 Buccal Tabs
Android®-10 Oral Tabs
Android®-25 Oral Tabs

Methyltestosterone U.S.P. – 5, 10, 25 mg.

New Double-Blind Study ANDROID-25 *vs.* Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + 25% improvement; + + = 50% improvement; + + + = 75% improvement. Placebo effectiveness was + or + + in 12.7% of trials. Android-25 elicited a +, + + or + + + response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D., and D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974 **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250 Rx only

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"... because organized medicine's political arm is effective ..."

As the Chairman of the American Medical Political Action Committee, (AMPAC), I'd like to respond to some thoughts presented by Joel I. Hamburger, MD, in an article which appeared in the May, 1977, edition of *Michigan Medicine.*

Doctor Hamburger's stated concern in the story was his feeling that American medicine's biggest problem today is public relations. In the article, he recounts a number of "sins" which he asserts account for our "poor image." I would like to comment on one of these points he's listed.

The number one item on which Doctor Hamburger takes aim, is what he describes as the AMA's involvement in political activity. As one who has been involved with both state and national medical political action for some time, I'd like to put these facts to Doctor Hamburger.

1. The American Medical Association does not make political contributions. Since 1961, the political activities of organized American medicine have been taken care of by AMPAC. By law, AMPAC is a separate, segregated committee, designed to collect funds and make independent decisions as to how these monies are to be distributed. Although it is true that 10 members of the AMPAC Board are appointed by the board of trustees of the AMA, the AMA's influence in allocation ends there. Thus, the AMA, per se, is not directly involved in political campaign activity and any source that so attributes this type of activity to the AMA is out of step with what is fact.

2. I would also like to address Doctor Hamburger's basic premise that participation in the political system by physicians is bad for public relations. The suggestion that we, as physicians, should somehow abridge our First Amendment rights for the sake of appearance, is at first glance disquieting. However, I must agree with Doctor Hamburger that in many instances in the past, many political action committees have lacked the necessary finesse it takes to be involved in politics, and yet not appear to be clubbing the process to death.

My own feeling on this matter, after more than 15 years of participation, is that AMPAC is among the most sophisticated political operations in the nation at this time. This development is largely due to AMPAC's tenacious adherence to the spirit and letter of the law, and its prodigious efforts to continue any and all political activities which are legal. Yes, this means we must use large amounts of money to accomplish our goals, and yes, this means as a result, we are a force to be reckoned with in the political trenches. But since we are legal, and since we are effective, medicine's views continue to receive excellent hearings in the Halls of Congress, which is really what we're working for when all is said and done.

What is quite clear to us is that a major part of the reason we continue to come under fire by labor, Common Cause and the various governmental agencies thrashing about in our wake, is that we are good. Simple as that. It is because organized medicine's political arm is effective that we continue to receive abuse and harrassment.

I must ask Doctor Hamburger, "If your AMPAC organization was not a political shaker and mover, do you think all those groups would be wasting their time trying to destroy our public image?"

3. Finally, I sometimes wonder if we are worrying ourselves to death over this whole question of public relations. Of course, everyone wants to be liked by everyone, but we all know that isn't possible. Certainly, it may appear that everyone dislikes "big medicine" and its activities. But going back to my point on effectiveness, for how much longer can we really afford to divert our attention into this area? My personal concerns are centered around the questions of national public financing for campaigns, instant voter registration, the un-Hatching of all Federal employees, etc. All of these measures will have a direct bearing on how I will be able to practice medicine in the near future, and how Doctor Hamburger will also be able to continue his work. These bills will determine very specifically how well we will be able to combat the growing incursions of the state and federal governments into our practices.

Therefore, it seems to me, at this point in time, the profession of medicine should certainly be concerned about its public image. But at the same time, we should be fully aware of the political machinery now being set into place which would debase our work. I for one believe we must be ready to throw down an effective political gauntlet to any group or agency that would attempt to trample us, even at the cost of "public image."

Rex Kenyon, MD, Chairman
AMPAC Board of Directors

"Your journal is ... exceptional in quality and content ..."

Enclosed you will find my check for $11 for continuation of one year's subscription to *Michigan Medicine.* Your journal is very exceptional in quality and content and I look forward to receiving it each month.

Benedict Polup, MD
Elk Rapids

"... We (your patients) make our own pledge."

To the editor,

I am enclosing a copy of a letter which you may wish to consider using in a subsequent issue of ***Michigan Medicine****. The Byron Road Medical Group is a seven-man group of physicians in practice next to our hospital and they received the enclosed letter from a Mr. and Mrs. Bud Bekkering who included their four children's names.*

Sincerely,

Richard Lane
Administrator

Lately there has been a great deal of publicity on a subject that I think is as disagreeable to most lay people as it is to the members of the medical profession: the increasing incidence of malpractice suits. Our family, as a group, would like to take a positive position in this grim situation.

We have been patients at the clinic for over twenty years. At one time or another we have been treated by each of you and we have formed a deep respect and confidence in you. You have made calls to our home in the middle of the night. You have seen us through serious illnesses, calmed our fears when we were needlessly afraid, and preserved our peace of mind when real tragedy struck. There has never been a time when we were unable to reach one of you. We are truly grateful.

We feel that being grateful is not enough. It would be impossible to recompense you in a monetary sense for the services rendered to our family. It occurred to us that you should be able to have the same confidence in us that we have in you, so to our doctors who labor under the Oath of Hippocrates, we make our own pledge.

We do swear that we will always deal with you truthfully.

We will follow your directions in all matters in which we seek your counsel.

We will respect your privacy, interrupting your leisure only when absolutely necessary.

If we are uncertain or dissatisfied with your treatment we will speak of it to you only.

We will not endanger your professional reputation with idle gossip.

We will remember always that your concern for us is purely professional, and will not form an unnatural dependence on you.

We recognize that we chose you to be our physicians ... you did not choose us to be your patients.

We will remember that you are human and can make mistakes, but we have confidence that you would never deliberately do anything that would harm us ... but since you are human and you can make mistakes we pledge that we will not hold them against you, or sue you in a court of law.

"Reviewing the special section ..."

Reviewing the "Special Section: Michigan Physicians' Vital Statistics" in the July issue of *Michigan Medicine*, I note in the table showing the number and percent of MSMS members by specialty that occupational medicine is omitted. There are more than 80 physicians — most of whom are MSMS members — practicing full-time occupational medicine in the state. Over 30 of them are board certified in occupational medicine.

Although occupational physicians are but a small fraction of the total practicing physicians in the state, they have the responsibility for the health care of a much greater portion of the state's population.

For this reason, the occupational physicians deserve much better recognition from MSMS than they receive at present.

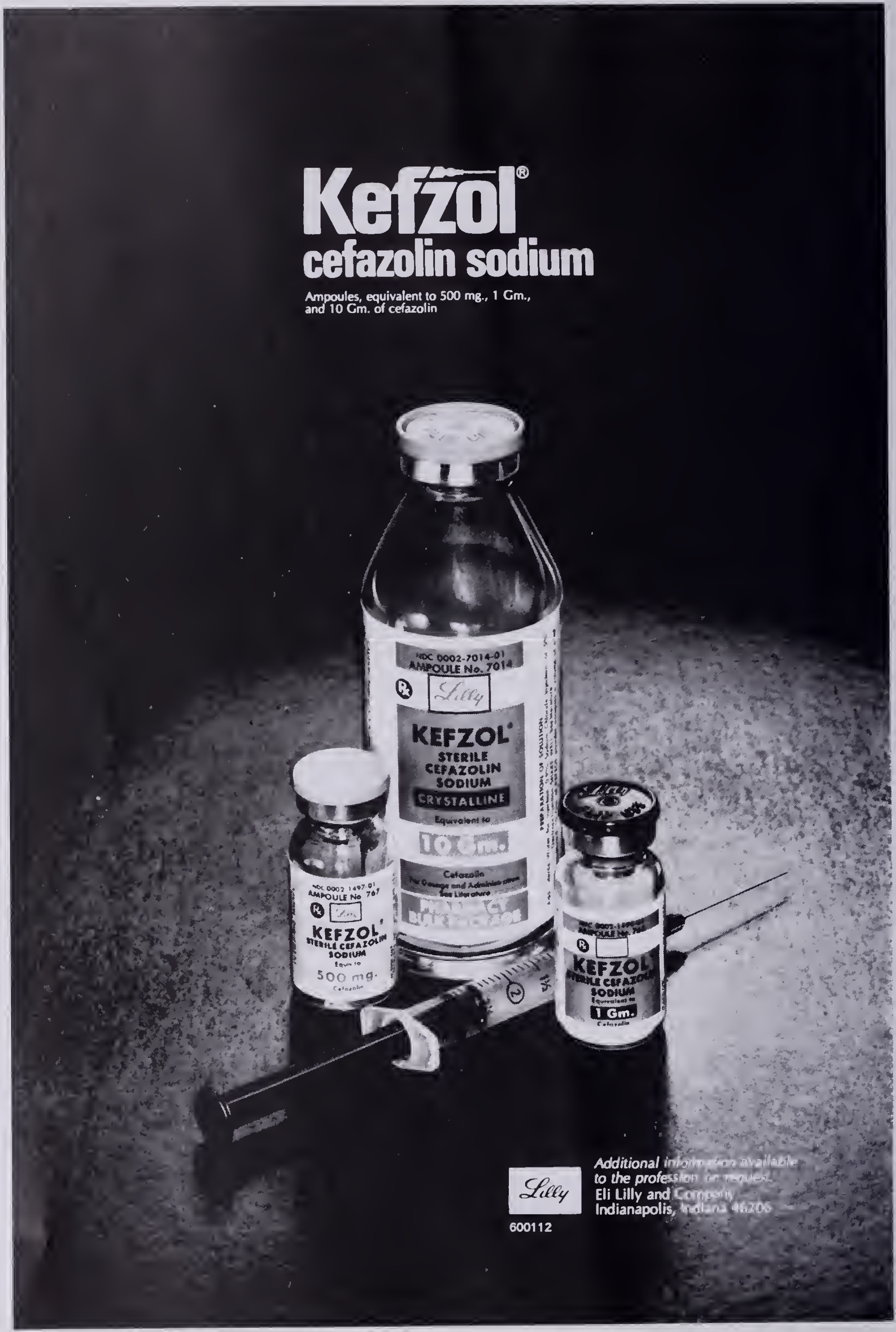
F. L. Purcell, MD
Medical Director

(Editor's Note: There are 83 medical specialties recognized by the American Medical Association. Not all were included in the MSMS list of figures published in the July issue, due to lack of space. We thank Doctor Purcell for his additional information.)

Thank you for sending the (July, 1977) copy of "Michigan Medicine." The report on MD Vital Statistics was very interesting, and I was pleased to see the Michigan Cooperative Health Information Statistics being put to use.

If any of your readers are interested in the complete MCHIS Report on 1976 Michigan physicians, we would be happy to send a copy, free of charge. MCHIS reports can be obtained by writing to Michigan Cooperative Health Information System, Department of Public Health; or by calling (517) 373-9000.

Rita Zemach, PhD, Chief
Statistics Research and Evaluation
Michigan Cooperative
Health Information System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Additional information available to the profession on request.
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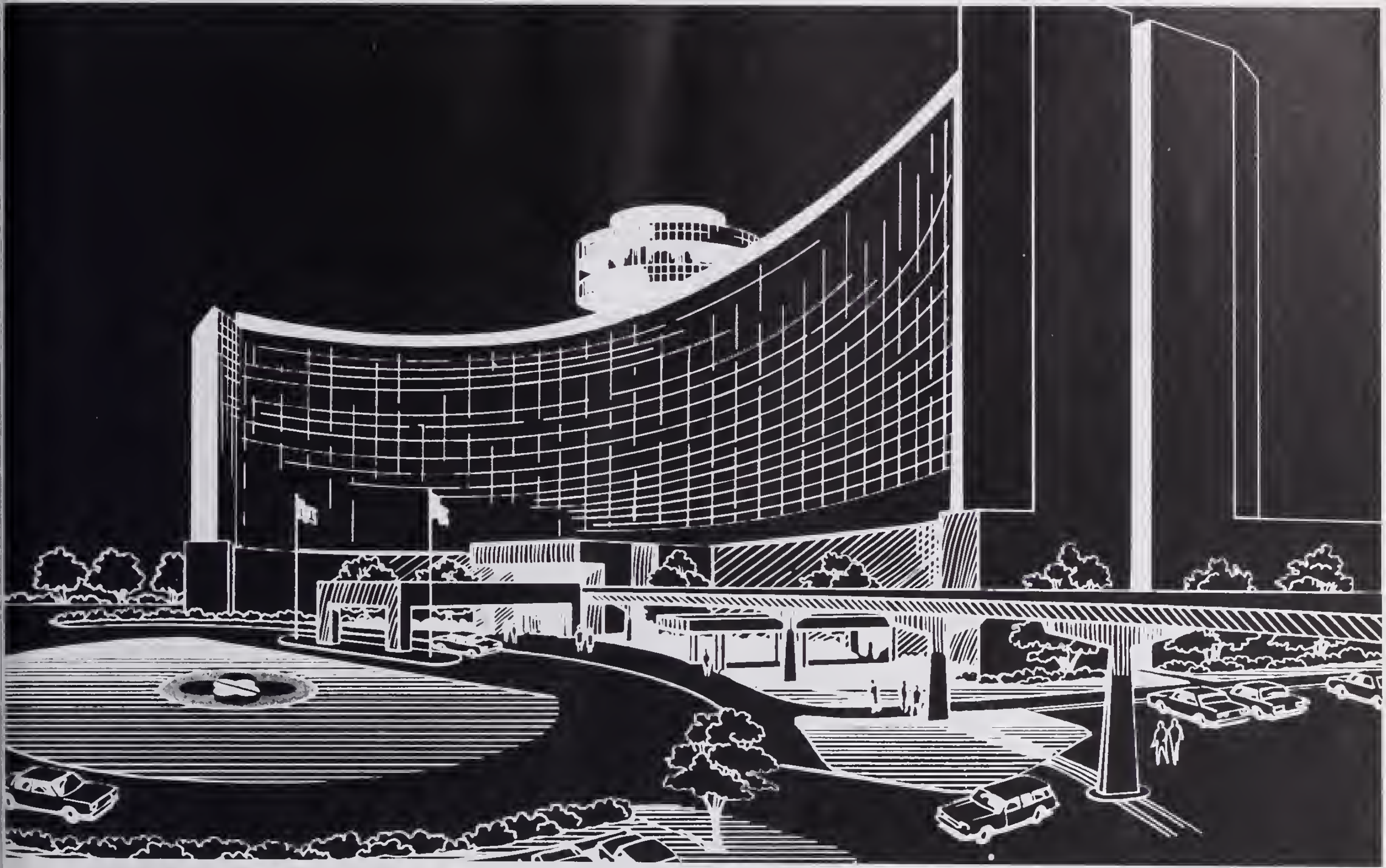
MSMS Scientific Meeting information on this and next three pages.



Hyatt Regency Dearborn again site for 1977 MSMS Scientific Meeting

This year's MSMS Scientific Meeting will be the second in a row to be held at the elegant Hyatt Regency Dearborn.

The 2,000-plus doctors who attended last year were pleased and generous in their comments on the adequacy of the facility, its service, meeting rooms, fine food and pleasant atmosphere.

And the adjacent Fairlane Shopping Center with more than 110 stores proved to be a popular sidelight for the many spouses attending. A person can leave the hotel's enclosed loading platform, board the climate-controlled people mover and be transported quickly directly to the shopping center without ever having to wear a coat or worry about the weather!

The added attraction of the nearby Greenfield Village, several fine eating establishments, etc. all combine to make this an exciting location for the Annual Scientific Meeting, Nov. 8-10, 1977.

The entire Fairlane complex covers 2,360 acres and is a far cry from its origins as Henry Ford's farmland home.

The $40 million Hyatt Regency Dearborn is one of the finest convention hotels in Michigan, and is reminiscent of other Hyatt hotels in Atlanta, Chicago, Los Angeles and elsewhere. A popular feature is the open atrium with its myriad of live plants and five glass enclosed elevators which move quickly, smoothly and silently.

The MSMS registration area and Exhibition Hall will be on the first floor, along with some of the larger courses. The second floor conference suite level, easily accessible with escalators, will hold most of the MSMS courses.

The spacious guest rooms begin on the third level of the atrium. The hotel features outstanding food and beverage services in a broad array of settings — La Rotisserie, Le Prelude, Kafay's Place, db's Club, the Rotunda and the LobbiBar. Name talent is featured regularly in db's Club.

Doctors and spouses should make their own room reservations direct with the Hyatt Regency, Fairlane Town Center, Dearborn, Mi. 48126.

30 sections, specialty societies planning courses

If early planning sessions are any indication, interest in this year's MSMS Scientific Session Nov. 8-10, Dearborn, is even greater than last year when some 2,000 physicians participated during the three days of meetings.

A major planning meeting at the Hyatt Regency Dearborn on June 16 drew 30 representatives of specialty societies to tell program chairman Robert F. Wilson, MD, of their particular plans. A similar meeting last year drew half that number.

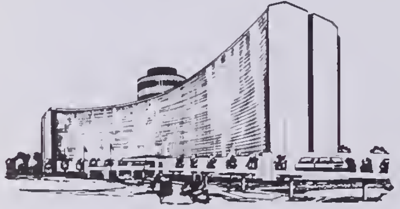
As of early September, 50 half-day courses already were being completed. Some specialty groups were still developing their courses.

This year all courses will be standardized at three hours, and on a uniform timetable. Thus, a physician needing to complete his Category I credit hours could earn up to 18 hours credit during the three days. And should he wish more, some additional hours will be available through self-instructional activities offered through the University of Michigan Media Library services.

Organizations and specialty society groups which had submitted preliminary program plans by Sept. 1 included:

American Medical Women's Association, Blackwell Branch
Michigan *Allergy* Society
MSMS Section on *Clinical Pharmacology*
Commission on *Professional and Hospital Activities*
Michigan Society of *Colon & Rectal Surgeons*
Michigan *Dermatological* Society
American College of *Emergency Physicians*/Michigan Chapter
Michigan Academy of *Family Physicians*
MSMS Section on *General Surgery*
University of Michigan Institute of *Gerontology*
Michigan Society of *Internal Medicine*
Michigan College of *Nuclear Medicine* Physicians
Michigan *Occupational Medicine Association*
Michigan *Ophthalmological* Society
Michigan *Orthopaedic* Society
Michigan *Otolaryngological* Society
Michigan Chapter, American Academy of *Pediatrics*
Michigan Academy of *Physical Medicine and Rehabilitation*
Michigan Academy of *Plastic Surgeons*
Michigan *Psychiatric* Society and Michigan *Psychoanalytic* Society
Michigan *Public Health* groups (Mich Dept of Public Hlth, Mich Pub Hlth Officers, etc.)
Michigan Society of *Therapeutic Radiology*
Michigan Society of *Thoracic Surgeons*
MSMS Section on *Thoracic Surgery*
National Foundation, *Ileitis and Colitis*
Michigan *Thoracic* Society
American *Urologic* Association/Michigan Branch

Tuition costs this year will be $3 per credit hour for MSMS members while non-members will pay $15 per credit hour. This means an MSMS member could earn up to 18 hours of credit for only $54 by attending all three days. A non-member would pay $90 for six hours or $270 for the same 18 hours over the three days, which is more than the cost of MSMS membership. Truly, the program is a member benefit.



50 Half-Day
Courses Set
Nov. 8-9-10
In Dearborn
Hyatt Regency

Fifty Category I courses available at MSMS Scientific Meeting

Physicians attending the 1977 MSMS Annual Scientific Meeting will have a very wide choice of subjects to study. Fifty half-day Category I credit courses will be offered Nov. 8-9-10.

Program Chairman Robert F. Wilson, MD, Detroit, announces that excellent courses have been planned by many specialty societies, MSMS sections and by department chairmen and professors of the three Michigan medical schools.

Faculty members will include noted medical authorities from other states as well as Michigan physicians with outstanding reputations in their special areas of medical practice or teaching.

The following list includes the titles of the courses according to each half-day course segment. Some of the courses are being offered by the Annual Scientific Meeting Committee in order to help provide a wide range of topics. Details about the instructors and course descriptions appear in the first September issue of the MSMS *Medigram*.

A registration form is on the inside back cover of this September issue, and will be printed again in *Medigram*. All courses will run for three hours this year with a half-hour break. The tuition will be $3 per hour, or $9 a course, for MSMS members, interns and residents; it will be $15 per hour or $45 per course for non-MSMS members.

• Tuesday Morning, Nov. 8

Basic Cardiac Life Support

Combined Medical and Surgical Approach to the Patient with Angina (Part I)

Diagnosis and Treatment of Thyroid Disease

Flap Surgery: Reconstruction Versus Blood Supply (Part I)

Myths, Perceptions and Realities: Physiological Aspects of Aging

Practical Otolaryngology

Prevention of Cardiovascular Disease: Diagnosis and Treatment of Hypertension and Hyperlipidemia

Recognition and Management of Sexual Problems in Clinical Practice

U-M Media Library

• Tuesday Afternoon, Nov. 8

Advances in Nutrition for the Practicing Physician

Appropriate Use of Physician Time in the Medical Audit Committee Function

Basic Cardiac Life Support

Combined Medical and Surgical Approach to the Patient with Angina (Part II)

Effective Utilization of Blood and Blood Products

Environmental Chemicals in Office Practice

Flap Surgery: Reconstruction Versus Blood Supply (Part II)

Radiation Therapy in Management of Breast and Colorectal Cancers

Treatment of the Elderly Patient: Practical Medical Guides

Why Wonder? — Just Call Nuclear Medicine

U-M Media Library

• Wednesday Morning, Nov. 9

Advances in the Understanding and Treatment of Acute and Chronic Renal Failure

Basic Cardiac Life Support

Health Problems of Children and Adolescents

Improving Physician-Patient Communications (or, How to Avoid Malpractice Suits)

Management of Acute Poisonings and Overdose

Management of the Multiple-Problem Child and His Family, Focusing on Myelodysplasia

Newer Developments in the Diagnosis and Treatment of Epilepsy

Para-Phenomena of Influenza

Practical Advances in Management of Pediatric Orthopaedics

U-M Media Library

• Wednesday Afternoon, Nov. 9

Acute Bronchial Asthma — Pathophysiology and Treatment

Advanced Cardiac Life Support

Colon-Rectal Surgery

Drug Allergy, and Drug-Related Reactions and Their Management

Latest Advances for the Specialist in Otolaryngology

Management of the Multiple-Problem Child and His Family, Focusing on Obesity

Practical Considerations in the Use of Steroids and PUVA

Urinary Tract Infection: A Burning Issue

What's New and Practical in the Management of Glaucoma and Cataract

U-M Media Library

• Thursday Morning, Nov. 10

Advanced Cardiac Life Support

Adverse Reactions to Drugs as Related to the Practicing Physician

Improving Physician-Patient Communications (or How to Avoid Malpractice Suits)

Newer Developments in the Diagnosis and Treatment of Hospital-Acquired Infections

Perspicacious Evaluation of the Patient with Multiple Injuries

Problems of the Young Athlete

Special Problems in Treatment and Rehabilitation of Burns and Injuries

Treatment of Symptomatic Coronary Artery Disease

U-M Media Library

• Thursday Afternoon, Nov. 10

Carcinoma of the Lung

Exercise in the Diagnosis and Management of Ischemic Heart Disease

Management Problems in Diabetes — 1977

- Management of Inflammatory Bowel Disease
- Manipulation and Mobilization in the Treatment of Musculo-Skeletal Myofascial Pain
- Role of the Practicing Physician in the Treatment of Breast and Colon Cancer
- Shock in Emergency Care: Prevention, Recognition and Management of Alcoholism
- Violence in the Family, and New Trends in Management of Alcoholism
- What's New in Surgery
- U-M Media Library

• Special Events in Addition To The Courses

WCMS Beaumont Lecture

The Wayne County Medical Society will hold its annual Beaumont Lecture Wednesday evening, Nov. 9 in the Hyatt Regency as one of the highlights of the MSMS meeting. All WCMS members have been invited, and all those attending the Scientific Meeting are invited to listen. There will be no charge for the lecture, which will provide one hour of Category I credit.

Michigan Orthopedic Society

The MOS will sponsor for members and other interested physicians a scientific program at the Dearborn Inn, at 4 pm Nov. 9 with Hugh Hickey, MD, Milwaukee, speaking on "Cryosurgery for Recurring Bone Lesions." One hour of Category I credit will be awarded by the MSMS Committee for CME Programming. Following the lecture there will be a cocktail reception and dinner for members of the Society and invited guests. Arrangements are being handled by Richard H. Allen, MD, society president, 191 College Street, Battle Creek, 49017.

Many physicians attending 1976 MSMS Scientific Meeting made use of the U-M Media Library

Register now to assure courses of your choice

Physicians planning to attend the MSMS Scientific Meeting November 8-10 at the Hyatt Regency Dearborn will do well to register in advance and as early as possible.

This advice comes from Program Chairman Robert F. Wilson, MD, Detroit, who offers it based on last year's experience.

"We began last year by planning to offer 20 courses to 1,000 physicians and ended by offering more than 40 courses to more than 2,000 doctors," says Doctor Wilson.

"We had many late registrants and walk-ins who simply could not be placed in courses they desired because the courses were filled." Some courses were repeated but even then could not handle all who wished to attend. More popular courses had to be closed to registration some two or three weeks before the meeting even opened.

Physicians needing additional hours or with specific interests in particular courses should use the registration forms printed in current *Medigrams* and send them to MSMS as soon as possible to assure attendance at the particular time and course. The registration process is speeded up and greatly enhanced if the appropriate registration fee based on the hours taken is included with the completed registration form.

"Avoid being disappointed," says Doctor Wilson. "Get your registration in the mail now."

U-M Media Library to offer credits again this year

One of the popular CME opportunities at last year's MSMS Scientific Meeting was the University of Michigan Media Library which offers physicians the chance to obtain Category I credit through independent study units.

Because it was so popular, the Media Library program again will be a feature of this year's meeting Nov. 8-10 at the Hyatt Regency Dearborn. The program will be housed in a larger room this year in order to permit more physicians to avail themselves of this opportunity.

Many of the accredited forms of self-teaching devices and programs will be available at the meeting. Display and sample programs will include the U-M Media Library's own materials; the American College of Surgeons medical skills library; Wyeth teaching machines; McGraw-Hill materials and Network for Continuing Medical Education programs.

Loop film projectors, video tape programs, audio cassettes, reading materials, and pre- and post-test materials are among the devices available to physicians electing to earn some of their credits in this manner.

Michigan State Medical Society has 26 positions

Efforts to further resolve professional liability situation

The 1977 Michigan State Medical Society House of Delegates at the May 13-15 annual meeting adopted the following 26 Position Statements (amended from the previous year's meeting) on professional liability:

- **Brown-McNeely Termination Date.** MSMS supports the state medical malpractice fund (Brown-McNeely) to serve, as an interim solution to the availability problem for physicians, but it should be dismantled as soon as the private sector can service the medical malpractice insurance market.
- **Brown-McNeely Assessment of All Physicians with Liability Insurance.** MSMS believes the Brown-McNeely Fund should be financed by premiums paid by those physicians insured by the Fund. If the Fund fails to adequately estimate losses to be incurred, the State general fund should provide for refinancing rather than an assessment against all physicians with liability insurance whether or not insured by Brown-McNeely.
- **Availability of Professional Liability Insurance.** MSMS believes that a physician-owned and controlled professional liability company (MPMLC) should be available to provide coverage up to, but not limited to, $200,000/$600,000. MSMS encourages private insurance companies to re-enter the Michigan market.
- **Professional Liability Reinsurance from AMA.** MSMS supports the new American Medical Association reinsurance company (AMACO) in its efforts to provide reinsurance to new doctor-owned insurance companies in all the United States.
- **Statistical Disclosure by Professional Liability Insurance Companies.** MSMS believes all insurors should disclose pertinent statistical information on claims, settlements and judgments, and that such information should be available for public review.
- **Arbitration — Voluntary and Binding Arbitration.** MSMS supports a dual system for handling of malpractice claims, with either binding arbitration or courtroom litigation available.
- **Arbitration — MSMS Supports Implementation.** MSMS vigorously promotes the use of voluntary and binding arbitration as a means of resolving professional liability problems.
- **Arbitration — Component Societies Monitoring.** It is official MSMS policy that each component society should establish its own arbitration implementation committee, to have at the local level sufficient expertise and interest to closely monitor arbitration as it is effected in Michigan.
- **Arbitration — Professional Panel Member Criteria.** MSMS believes the panel of medical arbitrators available for selection by parties to an arbitration proceeding should be as broadly representative of all medical disciplines as possible.

  MSMS believes the panel of attorney arbitrators available for selection by parties to an arbitration proceeding should be as broadly representative of all legal disciplines as possible.
- **Arbitration — Public Members on Panel.** MSMS encourages civic-minded members of the public to volunteer to serve as panel members in professional liability arbitration.
- **Definition of Malpractice.** MSMS believes the highest legislative priority should be given to a statutory definition of medical malpractice, to differentiate in law between malpactice and maloccurrence.
- **Limited Statute of Limitations.** MSMS supports efforts to establish by statute a fixed statute of limitations for all persons over the age of eight (8).
- **Alternative to the Contingency Fee System.** MSMS believes that organized medicine, with the Bar if possible, should seek an alternative to the contingent fee and thus the ultimate elimination of the contingency fee system at an appropriate time for legislative change or modification of our traditional system of jurisprudence.
- **Regional Restriction on Expert Witnesses.** MSMS supports legislation which would limit the use of medical expert witnesses to those experts who are in fact acquainted with the relevant standards of practice in the community situs of the claimed malpractice, or with the standards of a comparable Michigan community; and the expert witness must spend most of his time in clinical practice in the specialty of the defendant physician.
- **Waiver of Physician-Patient Confidentiality.** MSMS favors legislation to waive any physician-patient confidentiality privilege and/or hospital privilege concerning the patient's mental or physical condition at the date a malpractice action is filed. This would make available medical records of all physicians and hospitals with whom the patient has been treated in the time period embraced by a malpractice complaint.
- **Access to Medical Records.** MSMS favors legislation to systematize quick access to medical records by plaintiff attorneys prior

LIABILITY POSITIONS / *Continued*

to filing of a medical malpractice suit to facilitate the bringing of meritorious actions and inhibit the filing of nuisance suits. "Medical records" means the record of medical care and treatment maintained by a physician, hospital, or allied personnel defined in existing rules of the Department of Public Health, except that information used specifically for educational, research and experimental purposes may not be subject to discovery.

- **Study of Professional Liability by Health Planning Advisory Council.** MSMS supports continuous studies and monitoring of the professional liability problems by the State Executive Office. The Governor should assign this continuing task to the appropriate entity in his office.
- **Patient Responsibilities and Rights.** MSMS should develop a statement of patient's responsibilities and rights which will effectively communicate all those responsibilities and rights to all patients.
- **Monitoring of Expert Witnesses.** MSMS believes the quality of expert medical testimony needs to be monitored by the profession to assure competency. The appropriate component medical society and/or specialty society will be requested to monitor the testimony or review the deposition and render a written report on the quality of the testimony to the MPMLC Board and/or a task force of MSMS for review and appropriate action.
- **Continuing Medical Education.** That MSMS House of Delegates direct The Council to work to amend the law on continuing medical education to allow the accumulation of 150 hours over a three-year period.

  That MSMS House of Delegates direct The Council to work to change the relicensure law to a triennial schedule rather than the present annual schedule.
- **Support for Physician Countersuits in Nuisance Claims.** MSMS believes it should support physicians who are considering countersuits against a plaintiff or attorney, or both, following malpractice cases totally without merit. As MSMS cannot itself bring such a suit, it could assist the physician and his attorney by providing expert medical and legal review and research to support and encourage aggrieved defendant physicians in bringing counter actions.
- **Affidavit of Merit.** MSMS will pursue a statutory requirement that the plaintiff must provide an affidavit by an expert witness attesting to the merit of a complaint at the time a complaint is filed, as a deterrent to frivolous and nuisance complaints.
- **Ceiling on Awards for Pain and Suffering.** MSMS believes legislation should establish ceilings on pain and suffering awards. However, in a proven malpractice case, MSMS believes that actual damages should be awarded.
- **Permit Annuity Payments of Professional Liability Awards.** That MSMS seek legislation to permit the awarding of payments over a period of time, or corrective/rehabilitative services as well as lump sum payments when medical liability suits are settled in a court of law as are currently allowed by Michigan's Arbitration Law.
- **Burden of Proof.** MSMS favors legislation to require with specificity that malpractice, as defined in Position Statement 11, must be proven by the plaintiff before a verdict may be granted to the plaintiff.
- **Medical Practice Board.** MSMS favors full funding of the Medical Practice Board from existing income so that the responsibilities of the 1973 Medical Practice Act can be fully implemented before new changes in the law are effected.

Here is why MPMLC vetoed $10,000/$30,000

The Michigan Physicians Mutual Liability Company will not provide professional liability limits of $10,000 per occurrence and $30,000 annual aggregate. This was decided July 27 after the MPMLC board weighed both findings of an actuarial study commissioned by the company and the opinion of the company's legal counsel.

The decision was made even though a 1975 brochure published by MPMLC stated, "While not recommending low limits of coverage, the company will write such coverage for physicians who feel that it is all the insurance they wish to carry." A great deal has happened in the malpractice arena since 1975, and no one involved with MPMLC in 1975 could have foreseen that some physicians would begin to sue their insurers — and win those suits — on charges of selling inadequate professional liability coverage. MPMLC officials would not recommend low limits in 1975; they say they cannot, in good conscience, offer those limits in the medical malpractice climate of 1977.

"MPMLC has a responsibility to provide its members with adequate liability coverage at the best premium possible," says Vernon V. Bass, MD, MPMLC president and board chairman.

A study done by the company's consulting actuaries found that of medical malpractice cases closed with payment, 43 percent closed for more than $10,000, 24 percent closed for more than $25,000, and 14 percent closed for more than $50,000. These figures were derived from the All-Industry Special Malpractice Review sponsored by the American Insurance Association and the American Mutual Insurance Alliance, dated November, 1976.

The actuarial study also determined that MPMLC would have to charge 50% of the regular $100,000/$300,000 premium for $10,000/$30,000 coverage. "It behooves us to state that $10,000/$30,000 coverage is virtually useless for medical mal-

(Continued on page 460)

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All county jails in Michigan pilot program meet new national health care standards

By Elmer White
Special to **Michigan Medicine**

Adequate medical attention for inmates of the nation's county jails!

Three factors combine to make this a goal worthy of immediate attention. They are:

- A new sense of humanitarianism on the part of doctors, government officials and the public in general.
- A new sense of professionalism on the part of sheriffs.
- Perhaps most compelling of all, a new appreciation of counties' legal responsibilities to prisoners.

Financial liability

In 1976 the U.S. Supreme Court ruled that it is a county's obligation to provide adequate medical care for inmates of jails and that damages suffered by inmates could be grounds for suit against the county. Prisoners or former prisoners and their lawyers began to collect for what was claimed to be unnecessary suffering resulting from improper medical care. Some 150 cases are now pending.

Thus counties have had to protect themselves by insuring a reasonable level of medical attention. At the same time, sheriffs are taking increasing pride in operating the best jails possible, and many are aware there is room for improvement in health for inmates.

A federal agency, the Law Enforcement Assistance Administration, set up a $902,000 project to define ways to improve inmate medical care. Cooperating were the National Sheriffs' Association, the American Correctional Association, the AMA, MSMS and local medical societies.

Michigan was among six states chosen for pilot studies. Others were Indiana, Wisconsin, Georgia, Maryland and Washington.

Michigan's program excels

Results indicate that Michigan's efforts have attained great success. Working with the AMA, MSMS set up a program with Robert E. Medlar, MD, Jackson physician who is also a surgical consultant for Southern Michigan Prison as project medical director, and Richard M. Campau of the MSMS staff as project director.

Four Michigan counties (selected for a spread in inmate population and geography) became part of the program whose aim was to establish medical service for inmates at a level that would meet standards set by the AMA and thus become eligible for national accreditation. Such accreditation becomes a source of pride for the community, the enforcement system and the medical profession in each area.

Doctors made themselves available to help with the program in each of the four counties: Mustafa Avci, MD, Oakland; Paul Gikas, MD, Washtenaw; John Lyons, DO, Shiawassee; Austin Aardema, MD, Lake.

How does a jail become accredited? It meets minimum standards as defined by the AMA. These include reasonable concern for health care administrative structure; health screening of incoming inmates; appraisal of inmates' health status; provisions for emergency care, non-emer-

MSMS is a leader in improving health care to jail inmates.

All four county jails in an MSMS pilot project to upgrade care qualified for full accreditation and received their certificates Aug. 21-22 in Milwaukee at the AMA National Jail Conference.

The four jails, in Oakland, Washtenaw, Shiawassee and Lake counties, took part in a program headed by MSMS at the state level. All developed procedures which meet or exceed national recommendations.

Sixteen of the 30 pilot jails applied for accreditation in the six states taking part in the AMA-funded project.

Leaders in Michigan's jail health care project, from left, Paul W. Gikas, MD, Ann Arbor, project group member; Jay K. Harness, MD, advisor to the group and medical director, Michigan Department of Corrections; John Lyons, DO, project group member and director, Shiawassee County Health Department, and Robert E. Medlar, MD, Jackson, project medical director, meet below . . .

gency care, chronic and convalescent care and dental care; special attention for mentally ill and deficient inmates; drug and alcohol detoxification; adequate medical records; and hygiene.

Project director Campau worked with physicians, sheriffs and jail administrators in the four county jails, serving as liaison between them and the AMA. He reports that all local groups were anxious to upgrade their programs and facilities to meet the standards set.

Improvement now

Expectations are that the pilot study will mark the beginning of a new and improved level of medical treatment in which everyone can take pride.

. . . with Richard Campau, standing left, project director.

Communicable disease rate high in nation's jails

Inmates in the nation's jails exhibit an alarming incidence of communicable diseases, according to an inmate patient profile completed by the American Medical Association.

Examination of 641 prisoners in the AMA's jail health care project revealed:

- 12.9 per cent had positive test results for tuberculosis.
- 5.9 per cent had positive results for syphilis.
- 30 per cent had results indicative of liver malfunction, pointing to the possibility of hepatitis.

This high incidence of disease is especially disturbing because of the over-crowding common to U.S. jails. For example, in Cook County (Ill.) jail an undetected TB victim was introduced recently into a crowded tier of prisoners. Upon discovery, TB skin tests were given to 107 inmates who had been in close proximity to him. Twenty-three per cent showed positive reactions to the test.

Since many inmates are released within a short time of apprehension, their exposure to disease endangers the general population.

The inmate patient profile, which defines the problem for the first time, is an essential part of the AMA program to upgrade the medical care provided in American jails. The program, funded by the Law Enforcement Assistance Administration, has already produced a preliminary standard of medical care which is being implemented in the 30 jails participating in the AMA program.

Because of insufficient medical care which most inmates have during their lives — 15 per cent of those surveyed never had a physical examination, 16

per cent had never been to a dentist, and 26 per cent had never had their eyes examined — the inmates had a high percentage of unattended medical problems.

The AMA data show that 90 per cent of the inmates surveyed had at least one medical complaint and in 60.9 per cent of those cases, recommendations were made by the examining health professional that follow-up care was necessary.

The need for the AMA project has been underscored by the number of lawsuits by inmates which cite the lack of medical care as evidence of cruel and inhuman punishment. Less than 50 per cent of the jails originally surveyed by the AMA in 1972 provided a regular sick call, and only 17 per cent held sick call on a daily basis. Of those jails surveyed, 27 per cent had no emergency equipment at all, and six per cent did not even have a first aid kit.

Unlike the federal system of penal institutions, U.S. jails have been inadequate, medically, for years. The legal need for upgrading the nation's jails has been spelled out by three booklets produced by the AMA jail project.

One, *Constitutional Issues of the Prisoners' Right to Health Care,* documents the constitutional right of a prisoner to adequate medical treatment.

Another, *Legal Obligations to the Pre-Trial Detainee,* explores the rights of pre-trial detainees who must be given all due-process rights as non-prisoners, and who must have his health and well-being provided for and must, in fact, be accorded all the rights of a citizen.

A third, *Allied Health Personnel in Jails,* reviews the involvement of non-medical jail personnel in the delivery of medical care. These people can impede the delivery of health care, such as a guard deciding that a prisoner is malingering and not calling a physician.

The need for improvement of medical care, says AMA jail project director Joseph Rowan, goes beyond the legal niceties. "When a society removes the right of a person to be self-sufficient, then it must provide him or her with the basics of life."

Medicaid doctors may work harder, earn less money

Medicaid doctors may work harder and earn less money than physicians who treat relatively few Medicaid patients, an AMA study reveals.

An analysis of data from the AMA's Tenth Periodic Survey of Physicians, a random sample of 5,288 physicians practicing in the United States, determined that physicians with a higher proportion of Medicaid-eligible patients in their practices earned an average of $51,283 in 1974, while physicians treating fewer Medicaid-eligible patients had an average net income of $53,142.

Also, physicians with high Medicaid-eligible practices reported an average of 139.6 patient visits per week, while doctors seeing few Medicaid-eligible patients averaged 128 visits per week.

The statistics are contained in the new 1977 edition of *Profile of Medical Practice,* which together with the new 1977 edition of a companion book, *Reference Data on the Socioeconomic Issues of Health,* serve as quick reference guides for health professionals, policy-makers, researchers and journalists.

MPMLC/Continued

practice insurance," concludes the report.

This opinion is supported by the company's legal counsel. It is the MPMLC counsel's view that, because excess insurance is for all practical purposes unavailable, it is "important that the primary coverage be adequate to meet the current litigation climate." Adequate primary coverage protects not only the insured physician but also the physician's interest in the *mutual* company by guarding against potential bad faith suits against the company by insureds.

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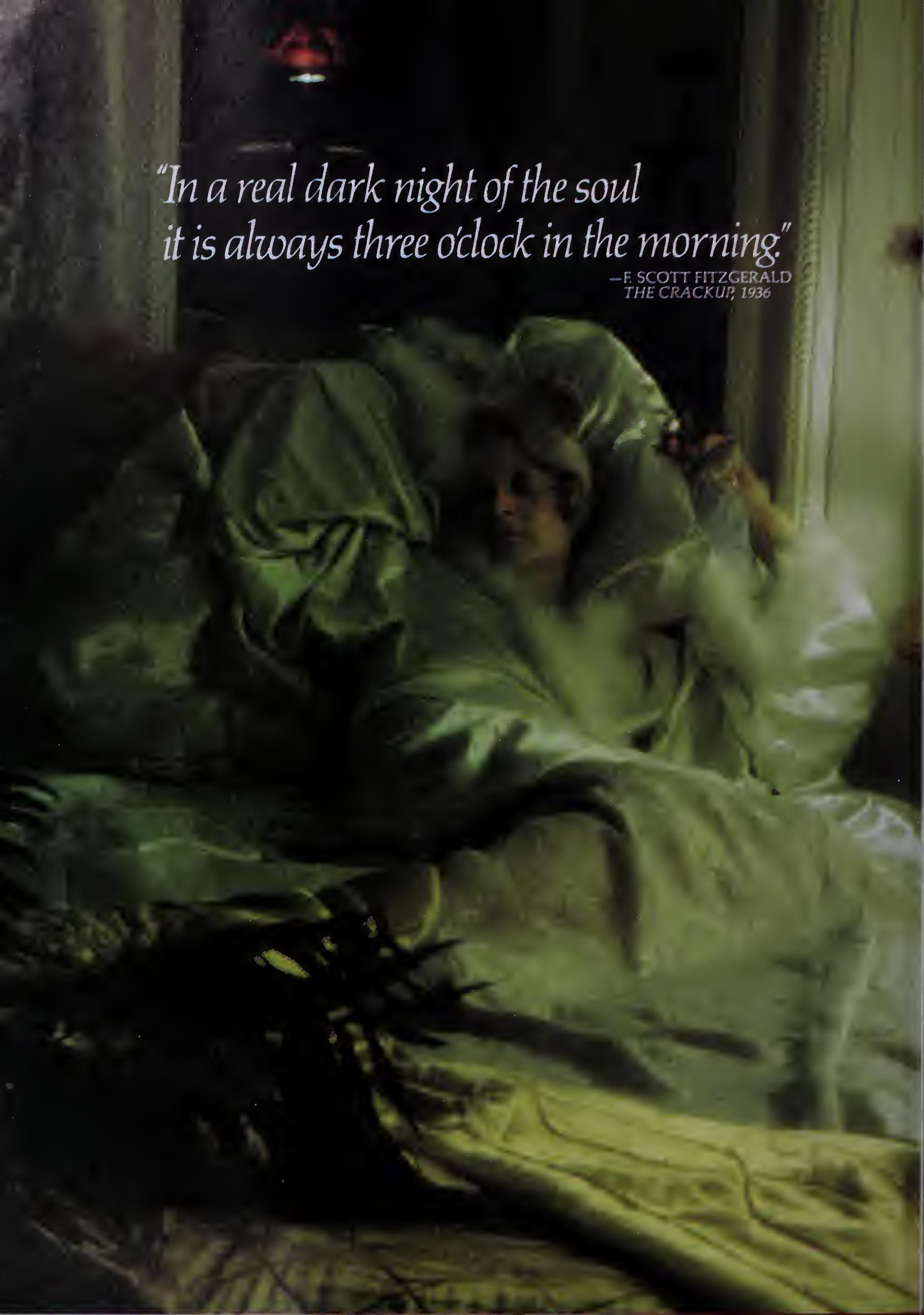

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1. Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974

Brief Summary of Prescribing Information
ADAPIN® (doxepin HCl) Capsules

Indications—Relief of symptoms of anxiety and depression.

Contraindications—Glaucoma, tendency toward urinary retention, or hypersensitivity to doxepin.

Warnings—Adapin has not been evaluated for safety in pregnancy. No evidence of harm to the animal fetus has been shown in reproductive studies. There are no data concerning secretion in human milk, or on effect in nursing infants.

Usage in children under 12 years of age is not recommended. MAO inhibitors should be discontinued at least two weeks prior to the cautious initiation of therapy with this drug, as serious side-effects and death have been reported with the concomitant use of certain drugs and MAO inhibitors.

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Precautions—Drowsiness may occur and patients should be cautioned against driving a motor vehicle or operating hazardous machinery. Since suicide is an inherent risk in depressed patients they should be closely supervised while receiving treatment. Although Adapin has shown effective tranquilizing activity, the possibility of activating or unmasking latent psychotic symptoms should be kept in mind.

Adverse Reactions—Dry mouth, blurred vision and constipation have been reported. Drowsiness has also been observed.

Adverse effects occurring infrequently include extrapyramidal symptoms, gastrointestinal reactions, secretory effects such as sweating, tachycardia and hypotension. Weakness, dizziness, fatigue, weight gain, edema, paresthesias, flushing, chills, tinnitus, photophobia, decreased libido, rash and pruritus may also occur.

Dosage and Administration—In mild to moderate anxiety and/or depression: 10 mg to 25 mg t.i.d. Increase or decrease the dosage according to individual response. **Usual optimum daily dosage is 75 mg to 150 mg** per day, not to exceed 300 mg per day.

Antianxiety effect usually precedes the antidepressant effect by two or three weeks.

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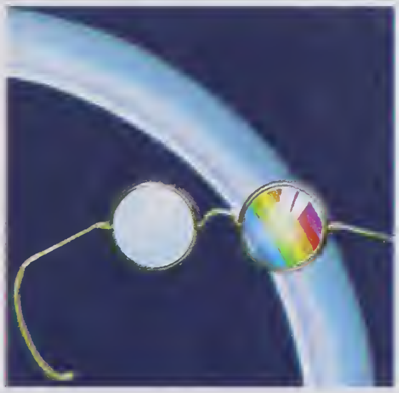

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(griseofulvin ultramicrosize)

Tablets 125 mg

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Gris-PEG®

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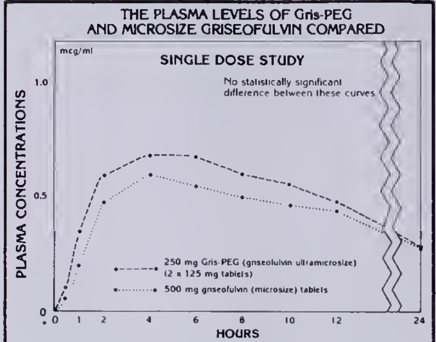
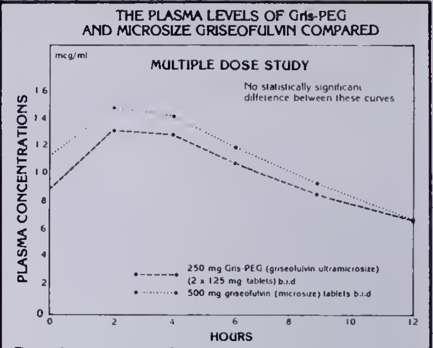
The ½ dose griseofulvin.



Based on a single dose double-blind bioavailability study conducted in 24 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels. There is no significant difference between peak plasma levels, times to peak, and areas under the curve. Gas chromatographic assay.



Based on a double-blind multiple dose steady state crossover bioavailability study conducted in 17 human volunteers comparing the average griseofulvin (microsize) and Gris-PEG plasma levels obtained on days 9, 11 and 13. There is no significant difference between times to peak, peak plasma levels, and areas under the curve. Gas chromatographic assay.

DESCRIPTION

Griseofulvin is an antibiotic derived from a species of *Penicillium*.

Gris-PEG is an ultramicrocrystalline solid-state dispersion of griseofulvin in polyethylene glycol 6000.

Gris-PEG Tablets differ from griseofulvin (microsize) tablets USP in that each tablet contains 125 mg of ultramicrosize griseofulvin biologically equivalent to 250 mg of microsize griseofulvin.

ACTION

Microbiology: Griseofulvin is fungistatic with *in vitro* activity against various species of *Microsporum*, *Epidermophyton* and *Trichophyton*. It has no effect on bacteria or other genera of fungi.

Human Pharmacology: The peak plasma level found in fasting adults given 0.25 g of Gris-PEG occurs at about four hours and ranges between 0.37 to 1.6 mcg/ml.

Comparable studies with microsize griseofulvin indicated that the peak plasma level found in fasting adults given 0.5 g occurs at about four hours and ranges between 0.44 to 1.2 mcg/ml.

Thus, the efficiency of gastrointestinal absorption of the ultramicrocrystalline formulation of Gris-PEG is approximately twice that of conventional microsized griseofulvin. This factor permits the oral intake of half as much griseofulvin per tablet but there is no evidence, at this time, that this confers any significant clinical differences in regard to safety and efficacy.

Griseofulvin is deposited in the keratin precursor cells and has a greater affinity for diseased tissue. The drug is tightly bound to the new keratin which becomes highly resistant to fungal invasions.

INDICATIONS

Gris-PEG (griseofulvin ultramicrosize) is indicated for the treatment of the following ringworm infections

Tinea corporis (ringworm of the body)
Tinea pedis (athlete's foot)
Tinea cruris (ringworm of the thigh)
Tinea barbae (barber's itch)
Tinea capitis (ringworm of the scalp)
Tinea unguium (onychomycosis, ringworm of the nails)

when caused by one or more of the following genera of fungi:

Trichophyton rubrum
Trichophyton tonsurans
Trichophyton mentagrophytes
Trichophyton interdigitalis
Trichophyton verrucosum
Trichophyton megnini
Trichophyton gallinae
Trichophyton crateriform
Trichophyton sulphureum
Trichophyton schoenleini
Microsporum audouini
Microsporum canis
Microsporum gypseum
Epidermophyton floccosum

NOTE: Prior to therapy, the type of fungi responsible for the infection should be identified

The use of the drug is not justified in minor or trivial infections which will respond to topical agents alone.

Griseofulvin is *NOT* effective in the following

Bacterial infections
Candidiasis (Moniliasis)
Histoplasmosis
Actinomycosis
Sporotrichosis
Chromoblastomycosis
Coccidioidomycosis
North American Blastomycosis
Cryptococcosis (Torulosis)
Tinea versicolor
Nocardiosis

CONTRAINDICATIONS

This drug is contraindicated in patients with porphyria, hepatocellular failure, and in individuals with a history of sensitivity to griseofulvin.

WARNINGS

Prophylactic Usage. Safety and Efficacy of Griseofulvin for Prophylaxis of Fungal Infections Has Not Been Established.

Animal Toxicology: Chronic feeding of griseofulvin, at levels ranging from 0.5 to 2.5% of the diet, resulted in the development of liver tumors in several strains of mice, particularly in males. Smaller particle sizes result in an enhanced effect. Lower oral dosage levels have not been tested. Subcutaneous administration of relatively small doses of griseofulvin, once a week, during the first three weeks of life has also been reported to induce hepatomata in mice. Although studies in other animal species have not yielded evidence of tumorigenicity, these studies were not of adequate design to form a basis for conclusions in this regard.

In subacute toxicity studies, orally administered griseofulvin produced hepatocellular necrosis in mice, but this has not been seen in other species. Disturbances in porphyrin metabolism have been reported in griseofulvin treated laboratory animals. Griseofulvin has been reported to have a colchicine-like effect on mitosis and cocarcinogenicity with methylcholanthrene in cutaneous tumor induction in laboratory animals.

Usage in Pregnancy: The safety of this drug during pregnancy has not been established

Animal Reproduction Studies: It has been reported in the literature that griseofulvin was found to be embryotoxic and teratogenic on oral administration to pregnant rats. Pups with abnormalities have been reported in the litters of a few bitches treated with griseofulvin. Additional animal reproduction studies are in progress. Suppression of spermatogenesis has been reported to occur in rats, but investigation in man failed to confirm this.

PRECAUTIONS

Patients on prolonged therapy with any potent medication should be under close observation. Periodic monitoring of organ system function, including renal, hepatic and hematopoietic, should be done.

Since griseofulvin is derived from species of *Penicillium*, the possibility of cross sensitivity with penicillin exists; however, known penicillin-sensitive patients have been treated without difficulty.

Since a photosensitivity reaction is occasionally associated with griseofulvin therapy, patients should be warned to avoid exposure to intense natural or artificial sunlight. Should a photosensitivity reaction occur, lupus erythematosus may be aggravated.

Griseofulvin decreases the activity of warfarin-type anticoagulants so that patients receiving these drugs concomitantly may require dosage adjustment of the anticoagulant during and after griseofulvin therapy.

Barbiturates usually depress griseofulvin activity and concomitant administration may require a dosage adjustment of the antifungal agent.

ADVERSE REACTIONS

When adverse reactions occur, they are most commonly of the hypersensitivity type such as skin rashes, urticaria, and rarely, angioneurotic edema, and may necessitate withdrawal of therapy and appropriate countermeasures. Paresthesias of the hands and feet have been reported rarely after extended therapy. Other side effects reported occasionally are oral thrush, nausea, vomiting, epigastric distress, diarrhea, headache, fatigue, dizziness, insomnia, mental confusion, and impairment of performance of routine activities.

Proteinuria and leukopenia have been reported rarely. Administration of the drug should be discontinued if granulocytopenia occurs.

When rare, serious reactions occur with griseofulvin, they are usually associated with high dosages, long periods of therapy, or both.

DOSAGE AND ADMINISTRATION

Accurate diagnosis of the infecting organism is essential. Identification should be made either by direct microscopic examination of a mounting of infected tissue in a solution of potassium hydroxide or by a culture on an appropriate medium.

Medication must be continued until the infecting organism is completely eradicated as indicated by appropriate clinical or laboratory examination. Representative treatment periods are—*tinea capitis*, 4 to 6 weeks; *tinea corporis*, 2 to 4 weeks; *tinea pedis*, 4 to 8 weeks; *tinea unguium*—depending on rate of growth—fingernails, at least 4 months; toenails, at least 6 months.

General measures in regard to hygiene should be observed to control sources of infection or reinfection. Concomitant use of appropriate topical agents is usually required particularly in treatment of *tinea pedis*. In some forms of athlete's foot, yeasts and bacteria may be involved as well as fungi. Griseofulvin will not eradicate the bacterial or monilial infection.

An oral dose of 250 mg of Gris-PEG (griseofulvin ultramicrosize) is biologically equivalent to 500 mg of griseofulvin (microsized) USP (see ACTION Human Pharmacology).

Adults: A daily dose of 250 mg will give a satisfactory response in most patients with *tinea corporis*, *tinea cruris* and *tinea capitis*. One 125 mg tablet twice per day or two 125 mg tablets once per day is the usual dosage. For those fungal infections more difficult to eradicate such as *tinea pedis* and *tinea unguium*, a divided daily dose of 500 mg is recommended. In all cases, the dosage should be individualized.

Children: Approximately 5 mg per kilogram (2.5 mg per pound) of body weight per day is an effective dose for most children. On this basis the following dosage schedule for children is suggested: Children weighing over 25 kilograms (approximately 50 pounds) 125 mg to 250 mg daily; children weighing 15-25 kilograms (approximately 30 to 50 pounds) 62.5 mg to 125 mg daily; children 2 years of age and younger, dosage has not been established.

Dosage should be individualized, as is done for adults. Clinical experience with griseofulvin in children with *tinea capitis* indicates that a single daily dose is effective. Clinical relapse will occur if the medication is not continued until the infecting organism is eradicated.

HOW SUPPLIED

Gris-PEG (griseofulvin ultramicrosize) Tablets (white) differ from griseofulvin microsized tablets (USP) in that each tablet contains 125 mg of ultramicrosize griseofulvin, biologically equivalent to 250 mg of microsized griseofulvin. Two 125 mg tablets of Gris-PEG are biologically equivalent to 500 mg of microsized griseofulvin. In bottles of 100 and 500 scored, film-coated tablets.

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OY-YE

MSMS streamlines committees; your time, talents needed

By Ernest P. Griffin, Jr., MD
Chairman, MSMS Council

The Council of MSMS is implementing a new, streamlined committee structure designed to enable your state society to respond to issues confronting the medical profession.

And there is a role for interested members to play.

Recognizing that MSMS must react rapidly and decisively to constantly-changing pressures on medicine, the 1976 House of Delegates authorized The Council to appoint a Task Force on Committee Structure. The Task Force was to study existing committees for their relevance to current MSMS objectives and to make recommendations to streamline committee activities.

This Task Force was led by Allen F. Turcke, MD, Flint, and drew upon Gordon Thomas, secretary to the Michigan State University faculty and well-known communications expert. The following recommendations of the study group were approved by the 1977 House of Delegates:

Three types of committees

MSMS shall have the following categories of committees:

Standing Committees to deal with continuing scientific advancement, legislation, negotiations, publications, public service, and other areas The Council deems necessary.

Liaison Committees to carry out MSMS relationships with such selected organizations and agencies as The Council decides; i.e., Medicaid officials, Medical Practice Board, Michigan Department of Public Health, governor's office, MSMS Auxiliary, the medical assistants and medical schools.

Task Forces which shall be created by The Council to handle specific assignments. Each task force shall study certain problems and recommend action to The Council. When the assigned job is completed, the task force will be disbanded. Members will be appointed by the Council chairman, with approval of The Council, because of their special knowledge and/or interest in the task force assignment.

House of Delegates Committees. The House may identify areas of concern and instruct The Council to appoint committees or task forces to study or act on those issues. The House itself will have only necessary internal committees such as Credentials, Rules and Order of Business, Constitution and Bylaws, and Ways and Means.

The House specified that The Council would have the responsibility for implementing these recommendations, and the appointment, coordination, and operation of all MSMS task forces and committees.

The House also requested that each major committee include a member of The Council to improve communications.

The Council has moved forward, and, at its July meeting, approved a blueprint for re-organization of committees. According to the House's intent, the blueprint provides for appointment of 15 standing and liaison committees. (Previously MSMS had 42 such committees). Among these are the Committee to Assist Impaired Physicians, Committees on CME Programming, State Legislation, Negotiations, Maternal and Perinatal Health, Public Service, Medicaid Liaison, and Professional Liability. Additional standing and liaison committees will be added if needed.

Most issues, however, will be referred to task forces. At the end of each year The Council will report to the House of Delegates the work of the committees and task forces.

MSMS needs volunteers

MSMS must have on file names of MSMS members willing to accept task force assignments on short notice along with information on the volunteers' interests and special knowledge.

MSMS needs you, the members of MSMS, to volunteer your talents and time. You are invited to write MSMS, Box 950, East Lansing 48823.

Your MSMS House of Delegates and The Council provide leadership and serve as your spokesmen. Your MSMS staff can investigate and implement on your behalf. But only you can provide the manpower, knowledge, and drive to solve the problems that can preserve your profession.

This report would not be complete without a special vote of thanks to MSMS members who served on the Task Force on Committee Structure: Allen F. Turcke, MD, Chairman, Flint; R. Jack Chase, MD, Grand Rapids; Jean Holdredge Darling, MD, Troy; Robert J. Fisher, MD, Ypsilanti; Vickers C. Hansen, MD, Manistee; Leland E. Holly, II, MD, Muskegon; Eber B. Sherman, MD, Eaton Rapids; Timothy E. Talbott, MD, Grand Rapids; William D. Walters, MD, Battle Creek; Edward R. Weddon, MD, Stockbridge; John M. Woods, MD, Mt. Pleasant; Charles C. West, MD, Lansing; and Special Advisor Gordon L. Thomas of MSU.

Welcome

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Antonio A. Aguirre, MD
20450 Van Born
Dearborn Heights 48125

Charles D. Bukrey, MD
21 Michigan St., N.E.
Grand Rapids 49503

Brian A. Connolly, MD
1613 Buckingham
Birmingham 48008

Hernan A. Drobny, MD
Univ. Hosp. Dept. of IM
Ann Arbor 48109

Donald D. DuSold, MD
551½ Linn St.
Allegan 49010

David W. Eckert, MD
18101 Oakwood Blvd.
Dearborn 48124

M. Riad El-Khatib, MD
Meyers Rd.
Detroit 48235

Bhavani P. Garapati, MD
800 Woodward Ave.
Pontiac 48053

Ramabrahman Gullapalli, MD
800 Woodward Ave.
Pontiac 48053

Gandam S. Jayakar, MD
5024 Bedford
Detroit 48224

Jeffrey S. Katz, MD
29314 Tiffany Ct., E.
Southfield 48034

John T. Kennedy, Jr., MD
64 Bronson Medical Ctr.
Kalamazoo 49006

Chang Dong Kim, MD
7145 Tireman
Detroit 48204

Robert K. Kreitsch, MD
235 Wealthy St., S.E.
Grand Rapids 49503

Wei Jeng Lin, MD
19630 W. McNichols
Detroit 48219

Arthur Manoli, II, MD
220 Eastland Prof. Bldg.
Harper Woods 48225

Andreas Marcotty, MD
28035 Southfield Rd.
Lathrup Village 48076

Henry D. Messer, MD
Wayne County Gen. Hosp.
Eloise 48132

B. Nanasimharaju, MD
2235 Inkster
Inkster 48141

Spyro G. Pappas, MD
22811 Mack Ave.
St. Clair Shores 48080

L. V. Regalado, MD
975 Merriman Rd.
Westland 48185

Leonard J. Rosen, MD
18239 W. 12 Mile Rd.
Lathrup Village 48076

Yucel Sezgin, MD
8190 Deer Creek Lane, E.
Canton 48187

Sudarshan K. Singal, MD
4727 St. Antoine
Detroit 48201

Mark G. Stenberg, MD
833 Lake Drive, S.E.
Grand Rapids 49506

William E. Thar, MD
Route #2
Decatur 49045

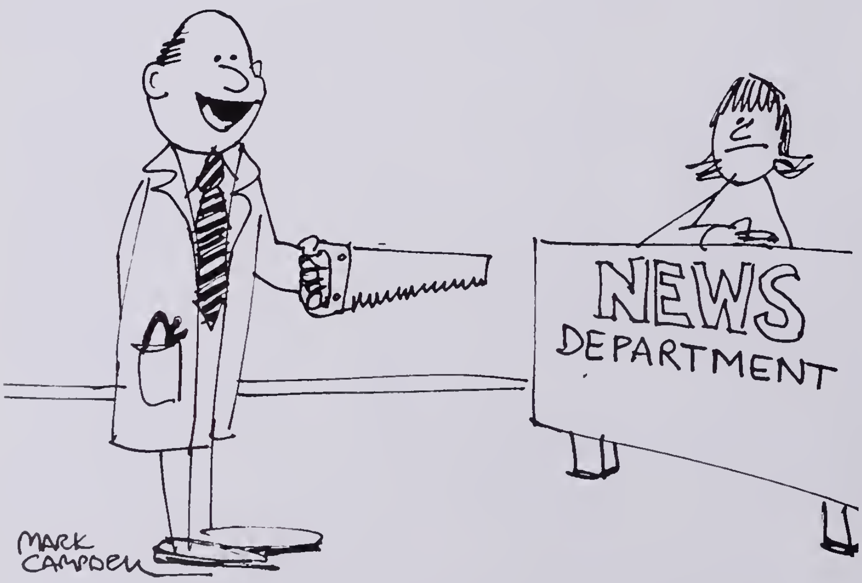
Yoeh Ming Ting, MD
P. O. Box 457
Bloomfield Hills 48013

Russell N. Van Houzen, MD
1100 Sixth St.
Traverse City 49684

Bose Yalamanchi, MD
1559 W. Big Beaver Rd. E-18
Troy 48084

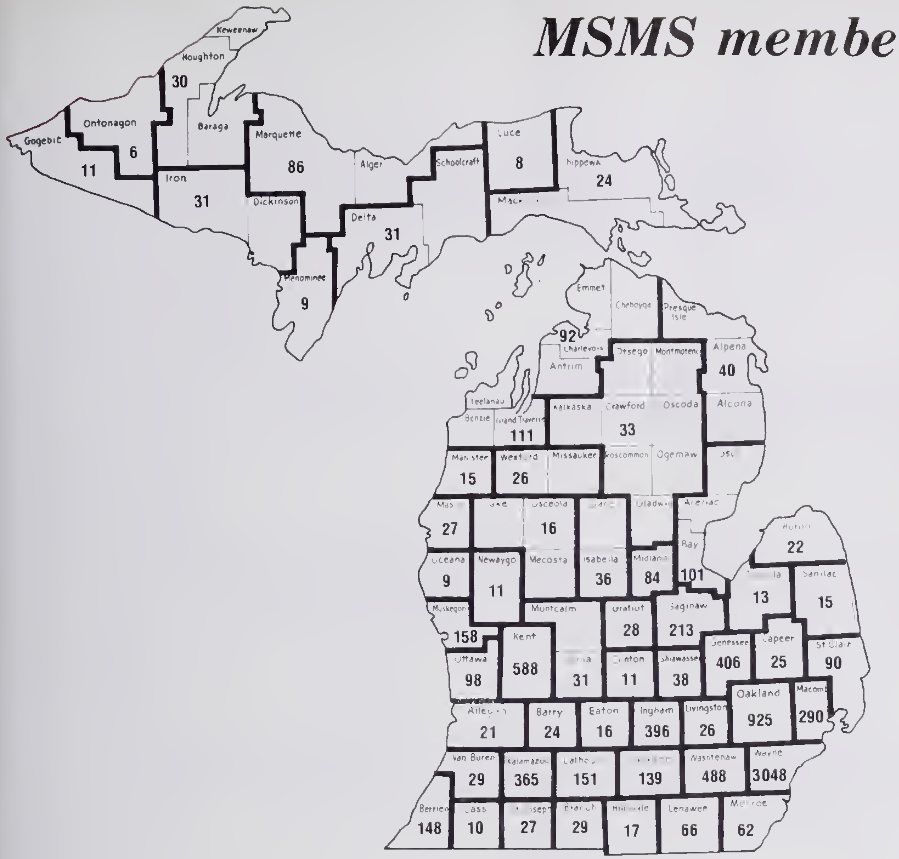
Steven J. Young, MD
319 Bronson Medical Ctr.
Kalamazoo 49006

Saeed K. Zanjani, MD
18500 W. 12 Mile Rd.
Southfield 48076



"Where is the reporter who did that article on unnecessary amputations?"

MSMS members by county


Keweenaw
Houghton
30
Ontonagon
6
Gogebic
11
Baraga
Iron
31
Marquette
86
Dickinson
Alger
Schoolcraft
Luce
8
Chippewa
24
Delta
31
Menominee
9
Emmet
Cheboygan
Presque Isle
92
Charlevoix
Antrim
Otsego
Montmorency
Alpena
40
Leelanau
Benzie
Grand Traverse
111
Kalkaska
Crawford
Oscoda
Alcona
33
Manistee
15
Wexford
26
Missaukee
Roscommon
Ogemaw
27
Osceola
16
Gladwin
Arenac
Huron
22
Oceana
9
Newaygo
11
Mecosta
Isabella
36
Midland
84
Bay
101
13
Sanilac
15
Muskegon
158
Montcalm
Gratiot
28
Saginaw
213
Kent
588
Ottawa
98
31
Clinton
11
Shiawassee
38
Genessee
406
Lapeer
25
St Clair
90
Oakland
925
Macomb
290
Barry
24
Eaton
16
Ingham
396
Livingston
26
21
Van Buren
29
Kalamazoo
365
151
139
Washtenaw
488
Wayne
3048
Berrien
148
Cass
10
27
29
17
Lenawee
66
Monroe
62

The total number of MSMS members, by county, are placed on the map at left. The numbers include life, retired and active members.

BURNS CLINIC MEDICAL CENTER

ANNUAL MEDICAL MEETING

To Be Held At Boyne Highlands
Harbor Springs, Michigan
September 30, 1977 — Friday 8:30 a.m.
October 1, 1977 — Saturday 8:30 a.m.

SEMINAR TOPICS AND GUEST LECTURES WILL INCLUDE:

EYE SEMINAR — HONORING *William S. Conway, M.D.*
Diabetic Retinopathy — *Morton S. Cox, M.D.*
Director, Retina Service
University Hospital
Ann Arbor, Michigan

TRAUMA SEMINAR
Chest Injuries — *Thomas E. Williams, Jr., M.D.*
Associate Professor of Surgery
Division of Thoracic Surgery
Ohio State University, Columbus

Closed Head Injuries — *R. Harris Russo, M.D.*
Assistant Professor of Neuro Surgery
University of Michigan Medical School, Ann Arbor

INTERNAL MEDICINE SEMINAR — HONORING *Benjamin B. Blum, M.D.*
Update on Inflammatory Bowel Disease — *William S. Haubrich, M.D.*
Head, Division of Gastroenterology
The Scripps Clinic & Research Foundation
LaJolla, Clinical Professor of Medicine
University of California, San Diego

CARDIOLOGY SEMINAR
Monitoring Pulmonary Artery Pressures in the Acutely Ill — *Daniel T. Anbe, M.D.*, Cardiologist
Henry Ford Hospital, Detroit

Topic to be announced — *Leo M. Henikoff, M.D.*
Acting Vice President for Medical Affairs
Acting Dean, Rush Medical College, Chicago

BANQUET SPEAKER — *Richard C. Bates, M.D., FACP*
Associate Clinical Professor of Medicine, Michigan State
"Auto Pollution"

M.S.M.S. CME Category I Credits. 10 credits will be awarded for attendance of the meeting.

FOR FURTHER INFORMATION:
A.D. Damschroder, M.D., Chairman
Burns Clinic Medical Center
Petoskey, Michigan 49770
Phone: (616) 347-7000 — Ext. 500

Registration fee for the meeting is $50.00.

REGISTRATION FORMS AND DETAILED PROGRAM WILL BE AVAILABLE IN AUGUST 1977

A simple investment program for your retirement trust

By David Buegeleisen
Southfield

Many physicians ask if they can direct the investments of their own pension and profit sharing trusts. The answer is, "Yes, they can." This article will outline a possible program for a physician who wishes to direct a trust's investments.

The primary reason for directing trust investments yourself would be to eliminate the fee which a bank trust department or an investment counselor would charge.

Bonds the primary vehicle

The program I outline here will meet all of the qualifications of the Employee Retirement Income Security Act.* The primary vehicles which would be used would be United States Government Bonds and life insurance. Also, a physician who is willing to spend the time might consider the use of high-grade corporate bonds. With bond yields currently running over eight percent on corporate bonds and over 7½ percent on government bonds, the rate of return could be projected without great concern over market fluctuations.

The major problem in using corporate bonds is that if interest rates were to fall, these bonds would be "called."

If AT&T issued bonds at nine percent, it would find it extremely advantageous to buy back the bonds if interest rates were to fall to eight percent. In the case of a bond with 20 years left to maturity of a $100,000,000 issue, buying these bonds back (this process is known as "calling" the bonds), would save the issuer $20,000,000 over the life of the issue if it were able to refund these bonds at eight percent. Therefore, in a period of falling interest rates, corporate bonds would be likely to be called.

US government bonds, on the other hand, are never called. And the rate of return on government bonds is only about one-half percent below the highest-rated corporate bonds. Thus, a physician would only have to sacrifice one-half of one percent in rate of return in order to be guaranteed that an investment would maintain the stated income for the life of the bond.

The US Treasury announces a refunding of the government debt on the last Wednesday of every January, April, July, and October. These are generally the best times to invest in government bonds as there are usually one or two long-term issues sold at these times. In recent years these refundings have provided some of the most attractive issues.

In addition to treasury bonds, there are offered, from time to time, treasury notes which have a life of 10 to 15 years. These notes can be used the same way as long-term bonds.

Advantages of bonds

The advantage of government bonds is that the compounding process will, over a long period of time, produce superb results. If a physician starting in practice were able to put $1,000 a year in his pension or profit-sharing trust for 35 years and was able to have it compound at a rate of six percent per year, he would have $119,121. Thus, $10,000 invested every year would be $1,191,210 at time of retirement.

The major disadvantage of this type of program is that there is no assurance of interest rates continuing at their present high level. During the past seven years we have seen historically high interest rates. It is extremely unlikely that these high interest rates will always be available. However, as long as interest rates on government bonds stay above six percent, this program would work very well.

How inflation affects trusts

The major economic worry of the past 10 years has been inflation. Many investors have attempted to outwit the effects of inflation in their investing programs-most with very little success. Let us consider the effects of inflation on pension and profit-sharing trusts.

The assets of the trust must be invested, thereby earning income. One of the first effects of inflation has always been that interest rates rise. Lenders are afraid that the lent money when repaid will have a lower purchasing power. They try to protect themselves against this loss of purchasing power by charging higher interest rates. In an inflationary environment the assets of the trust will be compounding at higher rates, offsetting at least a portion of the inflationary effects. Although there is a limit, by law, of 25 percent of the first $100,000 of income on the contribution that may be made to the trust, this limit is indexed for inflation. This percentage is currently running at 27 percent .Therefore, the effects of inflation are largely neutralized by the provision for higher contributions and the higher rates of return on the assets during inflationary periods.

If a physician were to use this type of program he would save between one and three percent administrative costs, which, in effect, boosts the rate of return. This type of program is particularly well suited for trusts with assets of less than $100,000.

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*Please refer to *Michigan Medicine,* March 1977, Volume 76, Number 8, Page 146, for "Some basic tips to prudent investing" — a discussion of acceptable Prudent Man investments under the Employee Retirement Income Security Act of 1974.

Mr. Buegeleisen is an investment counselor.

New Study Just Released!

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Now that many states have repealed their anti-substitution law, you can help reduce your patients prescription costs with quality generics. Prescribe Purepac, or request your pharmacists to dispense the Purepac brand.

Bio-availability data of Purepac manufactured pharmaceuticals and Generic Reference Chart are yours upon request.

*The November 1976 study by American Druggist Magazine reconfirms Purepac leadership over every other generic manufacturer.

Copies of this study, and Purepac's Annual Report are available.

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AMERICA'S LEADING NATIONAL BRAND OF GENERICS

What to do when the media abuse you

By Elmer White
Special to **Michigan Medicine**

So you've been abused by the media. Someone has printed or broadcast something inaccurate or unfair about you.

What do you do about it?

First review the incident. Is the report really something damaging or unfair, or did it just touch on an aspect of medical practice which is a tender point with you? Does it do any real harm, or is it just bothering you because the report was poorly done?

Let's assume the item was both damaging and unfair. Try to make an objective evaluation of your alternatives to improve things. Keep in mind that it is harder to be objective soon after you learn of an offensive message than later. A few days later is best for such consideration unless time is truly a factor.

Mr. White retired in 1976 as executive director of the Michigan Press Association. A veteran newspaper editor, he is retained by MSMS as a communications consultant, advising the staff and Committee on Public Service.

Best thing to do may be nothing

More often than not the best thing to do at this point is nothing. It is not very satisfying, but it is true. Usually the people offended are the only ones who really care much about the incorrect report; others were unimpressed the first time around or have forgotten about it. You can demand and often get a retraction. This might make you feel better, but it exposes many more to the earlier erroneous report. In other cases people who hear the retraction sometimes are really unconvinced.

Once you decide that the report was of a nature which could cause serious harm if uncorrected, or if your sense of outrage cannot be satisfied without action, there are things you can do.

Physicians may take steps

The simplest and often most effective is to call the reporter who erred. Identify yourself and express your disappointment (or whatever emotion ranging to wrath). Be explicit as possible about the error. Then be explicit as possible about the accurate information. Explain why it is you are concerned, including the harm which has resulted or might result from the mistake. If you are not satisfied following this conversation, consider the next step.

When you feel wronged by the media, there are several things you can do: You can contact the reporter, appeal to his boss, check with MSMS for media relations advice, or you can forget it. Lawsuits are impractical. They are expensive, lengthy and hard to win.

You can write a letter to the editor or station manager. Again it is important to be explicit. Paste the story on a sheet of paper and indicate in pencil the specific error you find. Try to tell the station manager the exact time the report came over the air and exactly what it said. Then state the correction needed to make the report accurate. A carbon of the letter should be sent to the offending reporter.

If some sort of satisfaction results, it is also a good idea to drop the top man a note thanking him for his interest. Maybe a carbon of that should go to the reporter.

Better relations may develop

The most effective relationship with media is not a one-time thing. You might think you didn't get anywhere with your complaint, but you have no way of knowing what happened in the media office.

One by-product of registering a complaint about an unfair report can be the establishment of a better line of communication. Most mistakes develop because reporters are not aware where they can verify facts and get information needed to enlarge or localize a story. Be sure to let reporters know that you or someone in your area is accessible to talk about medical news. If you are contacted, try to see the reporter's need is fulfilled.

There is help available for you when you are mistreated by media. Some local medical societies have staff people who keep contact with media people. MSMS works hard on a full time schedule to keep open the best lines of communication to important media outlets. MSMS and county offices have experience with many media problems. Call on the appropriate person at MSMS or the county level. Discuss your situation. Perhaps the intervention of a third party from one of these offices will ease the establishment of an accurate report. Perhaps you can get some information which will help in your case.

More Americans want health insurance locally controlled

There has been a significant decline in the number of Americans who want to see a national health care plan administered and controlled by the federal government.

At the same time there has been an increased interest in having health care administered by local government.

These are the finds of a recent Gallup Survey. The poll compared public attitudes in 1972 and in 1976 toward various proposals for delivery of health care.

The question asked of those polled in 1972 and again in 1976 was:

"Congress may soon pass some form of national health insurance partly paid for out of taxes. Who would you prefer to run this program?"

In 1972, 13 per cent favored a health plan run by local citizen organizations and doctors. This figure increased to 20 per cent in 1976. Those favoring a program run by local government increased from seven per cent to 11 per cent in the four years. Preferences for state government or insurance company supervision remained about the same.

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SOUTHFIELD
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Kellogg Foundation endows several state health projects

Michigan's Kellogg Foundation has made several major grants in recent months to medical programs within the state.

Following are some of the details:

SHOTS grant

A state-wide program has been launched to extend and improve upon the instruction of house officers in hospitals throughout Michigan.

First in the nation, this is an organized approach to the need to both stretch and spread physician manpower, especially in underserved rural areas. SHOTS (Statewide House Officers Training System) has been funded by a three-year grand of $166,575 from the Kellogg Foundation.

The Ann Arbor-based organization has the backing of the state's four medical schools, professional organizations and Michigan Blue Cross/ Blue Shield, according to SHOTS executive director, Robert B. Carbeck, MD. He is chairman of internal medicine at St. Joseph Mercy Hospital, Ann Arbor.

According to Doctor Carbeck, the SHOTS program will not change the residency system, but will enhance it by giving house officers the opportunity to sharpen their psycho-social skills, making them more efficient and better 'people doctors.' No other agency in Michigan offers this training. SHOTS overall goal is to increase the number of primary physicians in the state.

SHOTS initially will use a three-part approach to assisting training programs offered in Michigan community hospitals:

1. Pediatric evaluation: A study of pediatric house officer training, followed by assistance to programs in improving psycho-social training enabling doctors to confidently meet their patients' and families' emotional needs. Actor "patients" and videotapes will be used.

2. Team training: House officers will be taught to make better use of "physician extenders" such as clinical nurse practitioners and physicians' assistants.

3. Satellite rural clinics: For the first time, house officer physicians will be offered temporary placement in rural clinics without the obligation of a long-term commitment.

"We are hopeful that a significant number of these young physicians will want to make a career in rural areas after they experience the many related challenges and satisfactions," Doctor Carbeck says.

Emergency technicians

The Kellogg Foundation has awarded $248,340 to Grand Valley State Colleges to develop a model for local training of emergency medical technicians in rural areas of 12 western Michigan counties.

The three-year grant will fund a pilot program through which Grand Valley will help rural areas assess their needs for emergency medical services and develop training capabilities using local resources.

The twelve counties involved in the grant program are Allegan, Ionia, Kent, Lake, Mason, Mecosta, Montcalm, Muskegon, Newaygo, Oceana, Osceola and Ottawa.

The grant from the Battle Creek foundation will be administered by Dr. C. Mark Vasu, director of the Emergency Medical Technician Training Program in Grand Valley's School of Health Sciences.

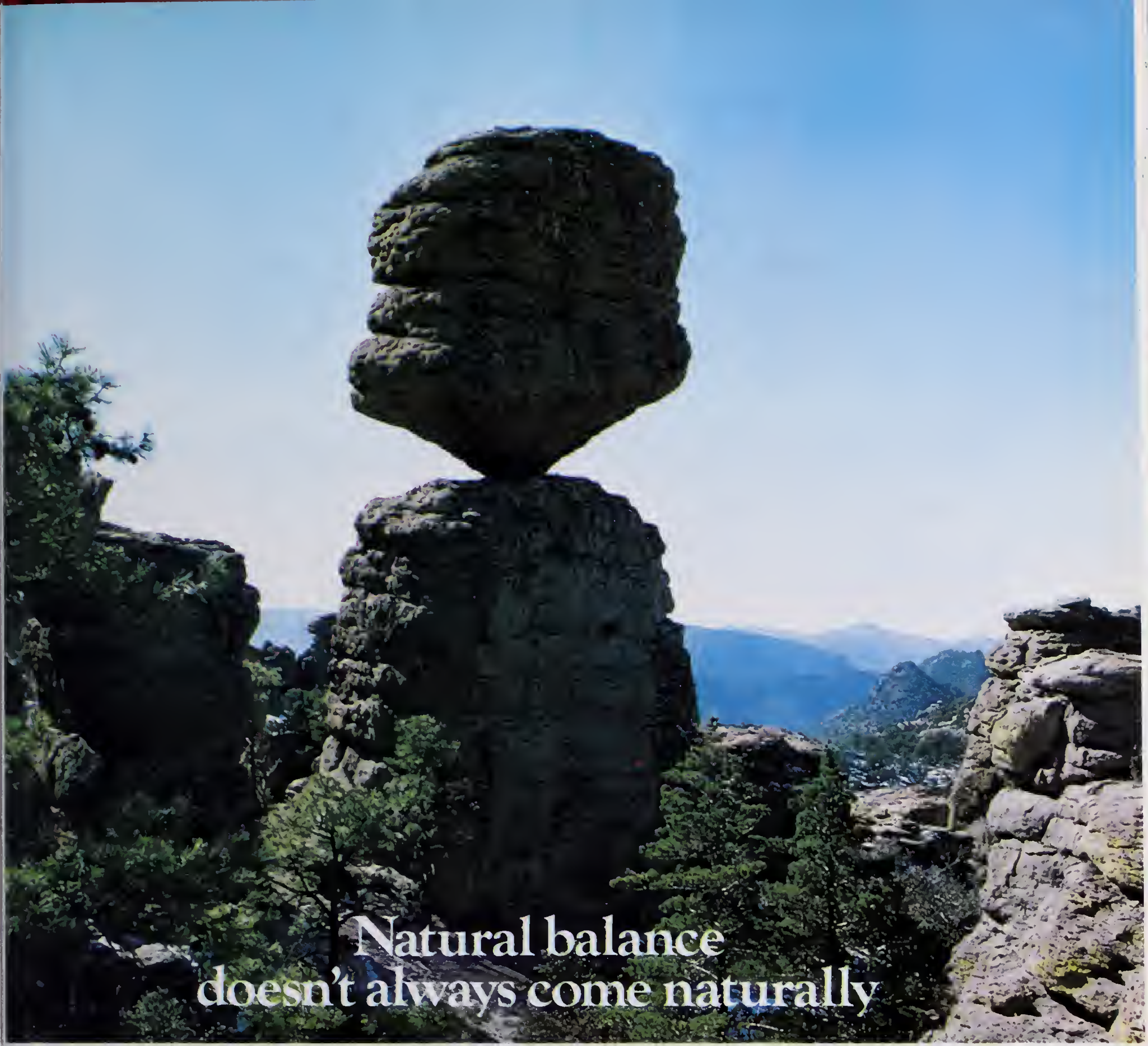
UP residencies

The Kellogg Foundation has awarded $1,283,845 to establish two demonstration Family Health Centers and a regional Family Practice Residency program in the Upper Peninsula. The grant has been made to the Upper Peninsula Health Education Corp.

The four-year award will assist the Upper Peninsula Medical Education Program in strengthening medical training in primary patient care in the Upper Peninsula. Funding for the 1977-78 year will total $252,088.

When fully implemented, the three-year family practice program will be training 12 residents at any time. Project director for the Kellogg Grant is Ronald W. Richards, MD, who also serves as program director for the undergraduate medical education program.

The Family Practice Residency program will be conducted in Marquette County.



Big Balanced Rock, Chiricahua Mountains, Arizona (approx 1,000 tons)

- **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with iseases affecting the vestibular system such as Menière's disease, abyrinthitis, and vestibular neuronitis.
- **Relief of Nausea and Vomiting**—Antivert/25 can relieve the ausea and vomiting often associated with vertigo.*
- **Dosage for Vertigo***—The usual adult dosage for Antivert/25 s one tablet t.i.d.

RIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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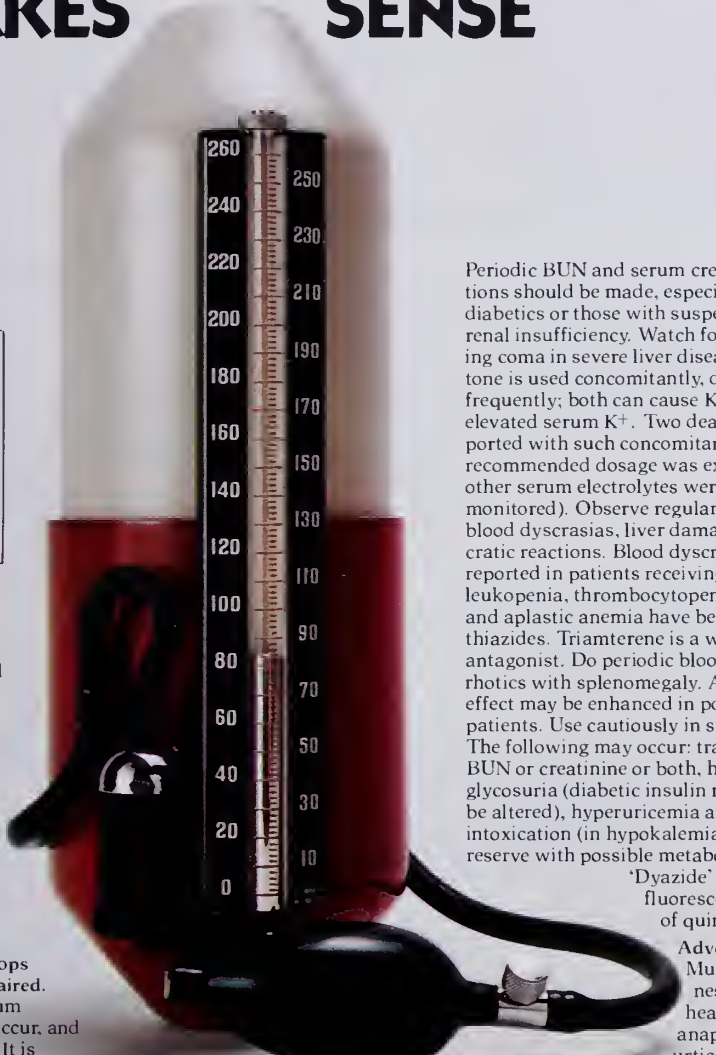

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* Warning
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K$^+$ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K$^+$ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K$^+$ frequently; both can cause K$^+$ retention and elevated serum K$^+$. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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Interaction with other CNS depressants. Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) may exhibit additive CNS depression; when used together reduce dose of one or both.
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Acute abdominal condition. These products or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.
Special risk patients. Administer with caution to certain patients such as elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.
ADVERSE REACTIONS: Most frequently include lightheadedness, dizziness, sedation, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; others include: euphoria, dysphoria, constipation and pruritus.
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If physician to mold future, must be involved in HSAs

Doctor Potter

By Richard O. Potter
Negaunee

Every physician should be aware of the term "Health Systems Agency" and the potential impact these agencies have on the practice of medicine.

Background

Public Law 93-641, known as the National Health Planning and Resource Development Act of 1974, supersedes the Comprehensive Health Planning Act and sets the stage for the planning of health services on a nationwide basis. It provides for a State Health Planning and Development Agency for each state (SHPDA) and a State Health Coordinating Council (SHCC) that is advisory to the state planning agency. Not less than one-half of the members of the SHCC shall be individuals who are consumers of health care and who are not providers of health care. Finally, it establishes approximately 200 Health Services Areas (HSA) throughout the United States.

The Health Systems Agency

The Health Systems Agency is the basic element of the law. Each is designated by the HEW Secretary after consultation with the governor of each state. It can be either a private, non-profit corporation or a public entity, and its board must have a majority of, but not more than 60%, consumers. In addition, the board must be broadly representative of the social, economic, linguistic and racial populations; geographic areas, and major purchasers of health care.

The purpose of the Health Systems Agency is to prepare and implement plans designed to improve the health of the residents of its health service area; to increase the accessibility, acceptability, continuity, and quality of health services in the area; to restrain increases in the cost of providing health services; and to prevent unnecessary duplication of health resources.

The agency is responsible for the production of two plans, the Health Systems Plan (HSP) and the Annual Implementation Plan (AIP). The HSP is a statement of goals used to describe the healthful environment and health systems in the area which, when developed, will assure quality health services that are available and accessible at a reasonable cost in a manner that assures continuity of care. Similarly, the AIP is used to describe the objectives which will achieve the goals formulated in the HSP, along with a determination of priorities among these objectives.

Implications for the physician

The definition of a provider is rather broad and includes all those who provide direct health services of any type and indirect providers such as health insurers and drug companies, as well as members of their immediate families; members of any policy-making board, such as hospital boards or boards of health. Given this broad definition, the limited size of the HSA boards and the required representation, there is little opportunity for many physicians to be appointed to HSA boards.

From an examination of the role of the HSA, its potential for affecting the physician and his or her practice is obvious. In addition, the need for expertise in the definition of problems and the determination of solutions that only the physician can give is quite apparent.

Despite the fact that there is a linkage with PSROs spelled out in the law, more active physician involvement in the process is vital. This involvement, to be most effective, should begin in the early stages of plan formulation since the opportunity to review the voluminous, detailed plans finally developed is often limited. Despite the limited opportunity to serve on an HSA Board or the board of one of its sub-area advisory committees, physicians can attend these board meetings, as they are open to the public. More importantly, the physician can serve on the various task forces that are working on such areas as physician manpower, health facilities and cost containment.

Collectively, medical societies can establish action-oriented committees that can keep abreast of the developing plans and provide comments to the HSA. Finally, both individual physicians and medical societies certainly should review the final documents which must be subjected to public review and comment before submission to the state agency.

Involvement by the physician will require an investment of valuable time, but if the physician is to have a part in the molding of the future of medical practice, it is an investment that must be made.

Dr. Potter is director, Marquette County Health Department.

Country Doc's Bookshelf

Plain medical speaking, writing seem at times truly endangered

By Norton Cooksey, MD
Northport

The English language is capable of grace and beauty, and can be used with precision and clarity. It is threatened, however, by a growing trend toward ugliness, obscurity and pomposity.

Edwin Newman, in his two books, *A Civil Tongue,* and *Strictly Speaking,* is currently a defender of our mother tongue against such vices. His books are witty, devastating and broadly indicting — and should be read by any doctor who thinks he can write — or wants to.

Newman is a long-time collector and reporter of mis-used and abused words and phrases, and his books are a gold mine, with a deep vein of humor, for anyone who respects words and language. "Will America Be the Death of English?" is the sub-title of *Strictly Speaking*, and he answers his own question in the first paragraph of the first page: "My well-thought-out, mature judgment is that it will."

Savor, for example, an old paragraph taken from a first edition of Laennec's *Diseases of the Chest,* first paragraph, first page: "Of all the diseases which are essentially local, those of the thoracic organs are unquestionably the most frequent; while in point of danger, they can only be compared with organic affections of the brain. The heart, lungs, and brain, constitute, according to the happy expression of Borden, the *triped of life* (italicized); and none of these organs can sustain any considerable or extensive morbid change, without the greatest danger. The delicacy of their organization and their incessant motion, account for the frequency and severity of their diseases."

Compare that with a contemporary sampling taken from Newman's second book, quoting directly from a publication of a rehabilitation hospital in New York State. It burbles on: "festering interfamilial meaningful relationships with counselees recovering from cardio-vascular pulmonary malfunctions." (page 139 of *A Civil Tongue*)

Surprisingly, Newman is strangely kind to doctors — by omission. Most likely, he simply hasn't gotten around to us yet. He bears down on the obvious targets: politicians and advertising men, newspapermen and educators, social "scientists" and psychologists.

But patients — yours and mine — could write their own books on us, for we're highly visible and audible targets. Every time we fail to explain clearly what it is that is wrong with a patient, or what we propose to do about it, we fuel the fire. Every time we hide behind our white coats, our charts and gadgetry, or retreat behind a fog bank of incomprehensible jargon, we court deserved and inevitable criticism. And occasionally law-suits!

Plain medical speaking and writing seem at times truly endangered. Like fields lain fallow for too long, they need a turning under of the rogue weeds and exposure of the deeper soil to the fresh air of criticism again.

It can be done. Journals *can* be informative, yet lucid and creative. Men like Franz Inglefinger and Lewis Thomas *are* with us, and there are many more about, in America, sometimes in unexpected places.

You may be one yourself. Write, and re-write. Tear it up, and write again. Come down from your own private Olympia and speak plainly to us mortals — or you just may find, as the politicians have, that you are speaking only to yourselves, and don't even know it.

Browse Edwin Newman at bedtime — you'll sleep with a smile on your face, having breathed fresher air than that to which you've become accustomed. Newman pleads his case well: "In arguing for a civil tongue, I am arguing for naturalness, even when it leads to mistakes. There is no reason that naturalness cannot be joined to correctness, but even when it isn't, clarity and genuineness can come together. More than this, we Americans don't have as much fun as we could with English. The fun is there to be had, but it requires some knowledge (which need not be formal), some imagination, and a sense of delight in what language can do."

Amen!

Doctor Cooksey is head (and comprises all) of the department of internal medicine at Leelanau Memorial Hospital, Northport. He formerly served on the staff of William Beaumont Hospital, Royal Oak.

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Progress of Michigan's 10 PSRO areas

Two of Michigan's 10 federally-designated areas now have Professional Standards Review Organizations in the second (or conditional) stage of organization. An additional six are in the first (or planning) stage, with another having just voted early in July to seek planning funds.

The remaining area — Area II, the northern third of lower Michigan — has not made any moves to organize a PSRO.

There are three stages of PSRO organization.

The East Lansing-based Michigan PSRO Support Center has assisted each of the PSROs in its development. PSROs are comprised of physicians and are charged with assuring health care services and items paid for by Medicare, Medicaid, and Maternal and Child Health and Crippled Children's programs, conform to appropriate professional standards and are delivered in the most effective, efficient and economical manner possible.

The Michigan Center, directed by Herbert Mehler since its inception in July, 1974 has had its contract renewed through March 31, 1978, by the National Professional Standards Review Council. The Center will continue to provide technical assistance and other services to the five recently-funded PSROs in Michigan.

There are currently 203 designated areas in the US, with 59 of them in the planning stage, 108 conditional and none in the final (fully designated) stage.

The following list describes the stages of development and leaders of each of the PSRO sections in Michigan:

- **Area I**

Upper Peninsula Quality Assurance Association
420 West Magnetic Street
Marquette, Michigan 49855
Phone: (906) 228-7685
Executive Director: Bradley N. Cory

Henry Barsch, MD, Chm.
William LeMire III, MD
Hugh Allott, MD
John Newkirk, MD
Merle Wehner, MD
George Wilson, MD

Awarded Planning Contract: June 27, 1974 Amount: $45,300 (6 mo.)
Awarded Conditional Contract: June 30, 1975 Amount: $1,165,620

- **Area II**

No activity at this time.

- **Area III**

Western Michigan PSRO, Inc.
2422 Burton, S.E.
Grand Rapids, Michigan 49506
Phone: (616) 942-6090
Executive Director: Harry J. Parke

Perry Greene, MD, Pres.
Robert Rice, MD, Vice-Pres.
John E. P. Burns, DO
John B. Uggeln, DO

Awarded Planning Contract: March 22, 1977 Amount: $110,938

- **Area IV**

Area IV PSRO of Michigan
3126 Davenport
Saginaw, Michigan 48602
Phone: (Not yet available)
Executive Director: Nicholes Vandenbelt

Ezra Bridge, MD, Chm.
John T. Baker, DO, Sec.

Awarded Planning Contract: March 2, 1977 Amount: $101,650

- **Area V**

Professional Review Organization — GLSC
920 Metropolitan Building
Flint, Michigan 48502
Phone: (313) 233-6071
Executive Director: Donald R. Blass

Fred Van Duyne, MD, Pres.
Glenn Blankenhorn, DO
Robert Roty, MD
Ray Engelman, MD

Awarded Planning Contract: June 24, 1974 Amount: $129,000
Awarded Conditional Contract: July 1, 1975 Amount: $1,051,695

- **Area VI**

Michigan Region VI PSRO
5030 Northwind Drive, Suite 205
East Lansing, Michigan 48823

Phone: (517) 351-4481
Executive Director: John E. Levin

Bernard Smookler, MD, Pres.
Thomas Barton, MD
Dorothy Carnegie, DO
Sidney Katz, MD
James Grost, MD

Awarded Planning Contract: March 24, 1977 Amount: $97,570

- **Area VII**

Area VII PSRO
210 Collingwood, Suite 220
Ann Arbor, Michigan 48103
Phone: (313) 668-6772
Executive Director: Kirsten I. Kingdon

Phillip O. Richards, MD
Carl Van Appledorn, MD
Scott Woods, MD
Sheldon Markel, MD

Awarded Planning Contract: March 15, 1977 Amount: $103,524

- **Area VIII**

Federation of Physicians in Southeastern Michigan
1010 Antietam Road
Detroit, Michigan 48207
Phone: (313) 393-0333
Executive Director: James L. Lang

Ralph Cooper, MD, Chm.
Sidney Adler, MD, Treas.
Robert Ogden, DO, Act. Sec.

Awarded Planning Contract: June 28, 1975 Amount: $165,708 (Expected to be Conditional about September, 1977)

- **Area IX**

Area IX Oakland-Macomb PSRO
Donald R. Blain, MD, Chm.

(No planning funds — Board meets on July 6, 1977 to determine future action)

- **Area X**

MAX PSRO, Inc.
(Office location to be selected)
Phillip O. Stott, MD, Chm.

Awarded Planning Contract: April 12, 1977 Amount: $103,173

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MSMS helps you to survive and have your voice heard as a responsible professional in an increasingly interdependent and socialized society.

Heartbeat

By Mert Scholten
MSMS Communications Department

Cornelius Alexander, MD, Kalamazoo, first black physician to serve as vice president of the Kalamazoo Academy of Medicine, was featured recently in a newspaper account of his retirement after 46 years of practice in the community. He is a general surgeon.

Richard J. Allen, MD, Ann Arbor, R. Gerald Rice, MD, Lansing, and Harry A. Towsley, MD, Ann Arbor, are among 18 Michigan citizens serving on Michigan's newly appointed Planning Council for Developmental Disabilities.

Tommy N. Evans, MD, Detroit, is president-elect of the American Gynecological Society. Chief of Gynecology and Obstetrics at Hutzel Hospital and professor and chairman of the Department of Gynecology and Obstetrics at WSU School of Medicine, Doctor Evans is a recent past president of the American College of Obstetricians and Gynecologists. He is also the director of the C. S. Mott Center for Human Growth and Development.

Robert N. Frank, MD, Detroit, WSU School of Medicine associate professor of ophthalmology since August of 1976, has been honored for his contribution to research in diabetic eye disease. He recently received the "Fight for Sight" Citation from the Association for Research in Vision and Ophthalmology. Doctor Frank has established a laboratory at the Kresge Eye Institute where he continues to study diabetic eye disease and to treat patients with eye complications of diabetes.

Many Michigan physicians have been contacted in recent weeks by the news media for advice about the latest diet fad - liquid protein. Roy J. Gerard, MD, left, head, MSU Department of Family Medicine, spoke with Detroit's Channel 2 reporter in an interview arranged by MSMS.

Norman "Pete" Johnson, PhD, Kalamazoo, is the new director of the Western Michigan University Physicians' Assistants Program. A '72 graduate of Purdue University, Doctor Johnson has been associate director of the Howard University PA Program for five years. In a note to MSMS, he expressed an interest "in discussing the PA concept with physicians from all over the state, especially from the rural areas where we feel they (PA's) can be most effective."

V. A. Stehman, MD, Ann Arbor, has been appointed director of the Prevention, Treatment and Normalization System, Michigan Department of Mental Health. He assumed the post in July, succeeding Floyd Westendorp, MD, who has returned to his post with the MSU College of Human Medicine's Department of Psychiatry.

Alfred B. Swanson, MD, Grand Rapids, lectured widely during the summer on joint implants at meetings in Denver, Boca Raton, Florida and several Michigan locations among others. He was also elected secretary general of the International Federation of Societies for Surgery of the Hand at the organization's annual meeting held in Edinburgh, Scotland. Following that meeting, Doctor Swanson presented a series of seminars in Germany, Spain, Hungary and Holland.

Edward G. Tracy, MD, professor of anatomy at WSU School of Medicine, recently was honored by the University as one of the first six recipients of the newly established Award for Excellence in Teaching.

B. David Wilson, MD, Portage, is the current president of the Michigan Allergy Society. He succeeded Helen Papaioanou, MD, Grosse Pointe. Doctor Wilson is a member of the MSMS House of Delegates representing the Kalamazoo Academy of Medicine.

Three Michigan physicians are on the current list of secretaries of the national medical specialty Boards — **N. D. Nigro, MD, Detroit,** American Board of Colon and Rectal Surgery; **Clarence S. Livingood, MD, Detroit,** American Board of Dermatology; and **W. P. Work, MD, Ann Arbor,** American Board of Otolaryngology.

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Rep. Larsen sees three areas for improvement of licensure setup

By Gene Hashley
Special to **Michigan Medicine**

Rep. Larsen

As a legislator, Mel Larsen has earned respect as a leader without a title. The close relationship Larsen has established with legislators of both parties has contributed to his success.

Since his election to the legislature in 1972, Larsen has been an acknowledged innovator in education, social services, senior citizens' issues and public health.

He currently serves as chairman of the House Republican Task Force on Education and was a member of the House Republican Task Force on Public Health Statues Revision Project (PHSRP). He is also the ranking Republican on the Appropriations Sub-committee on Social Services.

While a member of the PHSRP committee, which worked two years reviewing all of Michigan's public health statutes and codifying them, Larsen became knowledgeable about the public health care delivery system as it relates to the state laws governing it.

Physicians and regulation

He points out the medical profession and other health professionals have been responsible for developing a system of regulation that ensures a high quality of health care.

"Major impetus for the development of licensure has come from the professions. Prior to 1910, formal regulation of health care professions was almost nonexistent. But, due to the medical profession, medical care delivery has been greatly improved, principally through more stringent academic requirements and formal development of state licensure systems."

"The State's reliance on the profession to regulate itself has proven justified, but only recently have steps been taken to reorient the focus of the licensure system towards assuring the continuing competence of individual practitioners," Larsen says.

He points out three areas in which, he feels, the licensure system can be improved.

(1) Public accountability needs to be strengthened and, where feasible, participation by consumers must be increased to provide the necessary balance between professional control and public concern.

(2) While not endangering the quality of present health care services, licensure mechanisms should be altered to allow for the more efficient and effective use of existing health care providers.

(3) The effectiveness of the licensure system as a regulatory mechanism, as a tool to police the profession and further improve the quality of care, can be greatly strengthened.

The following article is the third in a series. The articles, written especially for *Michigan Medicine* by Lansing free-lancer Gene Hashley, profile Michigan legislators who are key figures in the formulation of health care legislation and programs.

Regarding the future of health care delivery, Larsen says, "It is apparent alternatives to costly institutional care must be a major priority. We in the political arena have an obligation to first deal with the health care cost issue."

"One of my major efforts in the legislature is to improve the health care delivery system for citizens in need of such services and to accomplish this within existing revenues," he says.

"In addition," he adds, "it must always remain a fundamental right of the consumer to choose the health care professional from whom he or she wishes care. At the same time, it is the state's responsibility to assure practitioners are competent."

Medicaid views

Larsen feels the Medicaid program reflects both best and worst of government. "The program has succeeded in substantially improving access to medical care for the poor. In many other respects, however, it has grown into a seemingly uncontrollable monster.

"Even though we had a substantial effort to develop a responsible cost containment package, one of every four new state dollars in the 1977-78 budget is for Medicaid.

"Thus far, we have failed at both federal and state levels to develop the fundamental oversight essential to establish program priorities. This makes it difficult to decide on program cutbacks during a fiscal crunch."

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Griffiths, L.L., Brocklehurst, J.C., MacLean, R. et al. *Diet in Old Age*, Brit. Med. J., 1:739, 1966.

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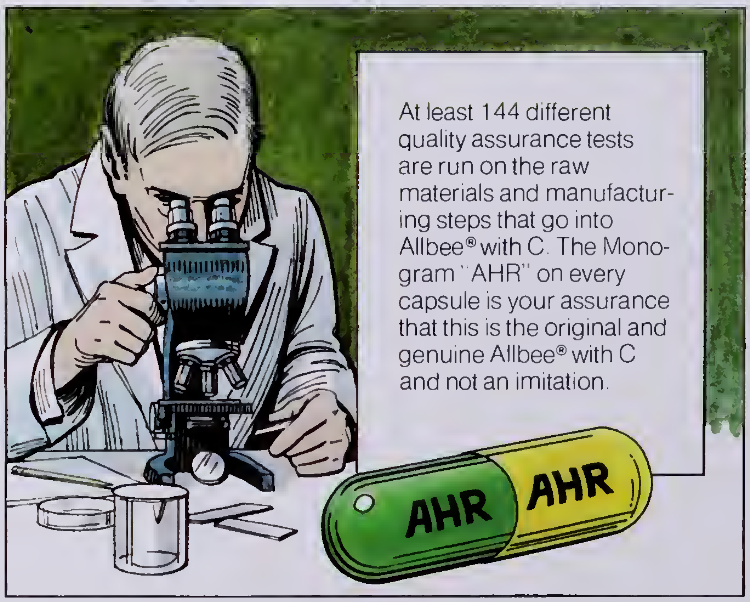

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How MSU's cooperative heart program enhances university, community education

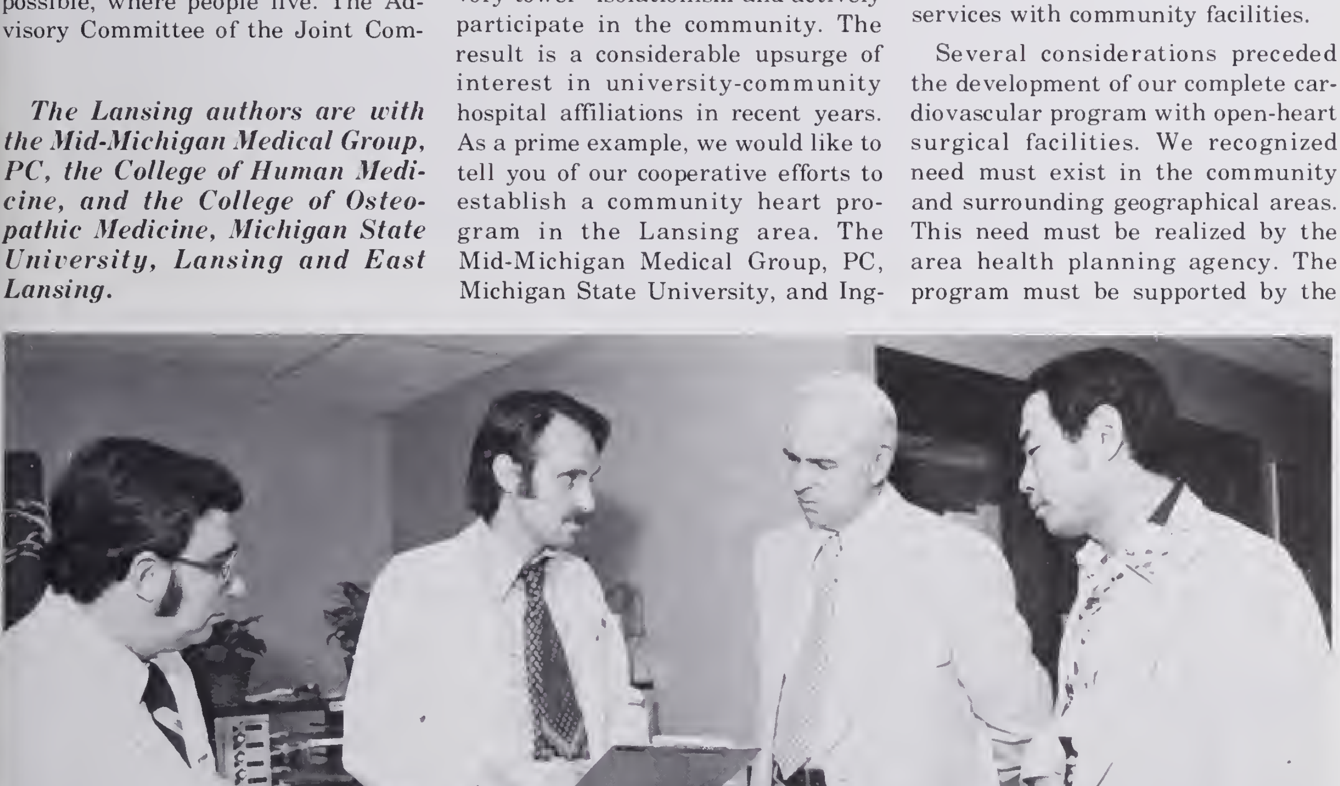
By L. Gonzalez-Lavin, MD
S. Chi, MD
M. Baird, MD
M. James, DO
A. W. Sparrow, MD
Lansing

High quality health care is needed and should be provided whenever possible, where people live. The Advisory Committee of the Joint Commission on Accreditation of Hospitals has pointed out that such services should be provided as close to patients' homes as possible without compromising opportunities for recovery. (The emergent nature of many cardiac ailments emphasizes this point.)

The Lansing authors are with the Mid-Michigan Medical Group, PC, the College of Human Medicine, and the College of Osteopathic Medicine, Michigan State University, Lansing and East Lansing.

Recognizing these health-care trends, universities are realizing that they must relinquish their "ivory tower" isolationism and actively participate in the community. The result is a considerable upsurge of interest in university-community hospital affiliations in recent years. As a prime example, we would like to tell you of our cooperative efforts to establish a community heart program in the Lansing area. The Mid-Michigan Medical Group, PC, Michigan State University, and Ingham Medical Center, recognizing the benefits each would derive from association with one another, set forth on a cooperative heart program; beginning with a cardiology program in 1972 and coordinating with a cardiac surgery program in March 1974. This program was structured to fulfill the demands of the community and the surrounding service area. It has become a unique demonstration in integrating university health care services with community facilities.

Several considerations preceded the development of our complete cardiovascular program with open-heart surgical facilities. We recognized need must exist in the community and surrounding geographical areas. This need must be realized by the area health planning agency. The program must be supported by the



Patient progress is discussed from left by cardiac surgeon Lorenzo Gonzalez-Lavin, MD; cardiologist George E. Kleiber, DO; cardiac surgeon T. Calvin Blair, MD, and cardiac surgeon Seong H. Chi, MD (MSU Photo) hospital staff, administration and board of trustees. Expertise in the areas of cardiology, anesthesia, and cardiovascular surgery with cardiopulmonary bypass are fundamental, as are experienced nursing personnel and adequate facilities, such as a clinical laboratory and blood bank. Hospital-based social work support is also needed.

Duplication of programs beyond the needs of the serviced population, either by multiple hospitals or multiple teams within a single hospital, is detrimental to each program and the personnel involved, increases total cost, and, of course, ultimately adversely affects optimum patient care.

Table I
Cardiac Catheterizations January 1, 1974-January 1, 1976

Category	Subtotals	Total
Adult catheterizations:		
Chest Pain Syndromes	263	
Valvular Heart Disease	46	
Miscellaneous*	55	
Postoperative Evaluation	20	384
Pediatric catheterizations:		109
		493

*Miscellaneous = ischemic and nonischemic cardiomyopathy, constrictive pericarditis, adult congenital heart disease, and pericardial effusion

Table II
Utilization of the Cooperative Cardiac Surgery Program

Year	Number of Cases Open and Closed Heart	Increase Over Previous Year
1974	68	
1975	122	79.4%
1976	131	7.4%

Aspects of this now well-established program are herein described to exemplify the work ability of a cooperative endeavor and to encourage others to consider university-community liaison in their chosen field of medicine.

Cardiac clinic

The Cardiac Clinic is the outpatient branch of the cardiac program. Comprised of several sub-clinics, patients are seen on an outpatient basis for a variety of reasons; new patients are assessed, treatment arranged, their course followed and later their progress is evaluated. There were 3,725 patient visits to the Cardiac Clinic in 1976; 2,594 (70%) of whom were seen in the adult cardiology clinics; 776 in the pediatric cardiology clinic; 355 seen in the cardiac surgery clinic.

Cardiac catheterization laboratory

From the period of Jan. 1, 1974 to Jan. 1, 1976, a total of 493 catheterizations were performed at Ingham Medical Center. These cardiac catheterizations were done in the diagnostic work-up of a wide range of cardiovascular diseases (**Table I**). They were done predominantly by the Sone's technique, and no mortalities occurred.

The fact that 82% of the 263 patients studied for chest pain syndromes had significant coronary artery disease defined as greater than 75% occlusion of one of the three major coronary arteries, indicates a very low percentage of normal patients studied, and suggests careful patient selection for cardiac catheterization. This is attributed to other noninvasive parameters which are also fully developed and utilized.

Pediatric cardiology program

In the Fall of 1972, development of the present structure of the cardiology program began. Over the succeeding three years, two full-time pediatric cardiologists joined the program. Twenty to 25 patients are seen each week in the pediatric cardiology outpatient clinic. Seventy-four percent of the pediatric cardiology patients forwarded to surgery have undergone open-heart procedures; a significant number necessitated correction during infancy, requiring profound hypothermia and total circulatory arrest techniques during the surgical repair.

An active consultation service is available to all Lansing area hospitals should infants or children with heart disease present in those institutions.

Cooperative cardiac surgery program

From its inception in March 1974, the cardiac surgery program has been structured with two cardiac surgeons already practicing in the community and a university cardiac surgeon.

Although numbers of operations alone do not attest to the growth of the entire heart program, they do give evidence of the need for, and the utilization of the program (**Table II**). A 79.4% increase in surgical cases in 1975 over 1974 (the initial year) emphasizes the area's demand for the program. Subsequent and continuing growth attests to its wider acceptance.

The program offers treatment for virtually all cardiovascular diseases amenable to surgery, as 28% of the procedures have been performed for congenital heart disease, 48% for ischemic heart disease, and 24% for acquired valvular and other acquired conditions. The percentage of all patients undergoing surgery who survive the operation and are discharged is 92.8 (**Table III**).

To attend the needs of patients in

(Continued on page 492)

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Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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Here's a sampling of other community-based MSU programs

The medical school/community partnership is fundamental to education and service programs of MSU's College of Human Medicine. Medical training is centered in Lansing, Flint, Grand Rapids, Kalamazoo, Saginaw and the Upper Peninsula where cooperative community programs for patient care also are concentrated.

Involved faculty from MSU represent departments of human development, family practice, medicine, obstetrics and gynecology, psychiatry, radiology and surgery.

In addition to the cardiac care program described by L. A. Gonzalez-Lavin, MD, (see accompanying article), a sampling of other community-based patient care programs includes:

- **E. W. Sparrow Hospital/MSU Kidney transplant program in Lansing (which also draws patient participation from Saginaw) includes a multi-disciplinary team;**
- **Patient care programs of the Community Mental Health Board in Ingham, Clinton and Eaton counties;**
- **Regional Diagnostic Service provided for children with multiple severe handicaps in Clinton, Eaton, Hillsdale, Ingham and Jackson counties;**
- **Prenatal Diagnostic Service, including a geneticist, pediatrician, obstetrician and a social worker, is provided at Grand Rapid's Butterworth Hospital and Flint's Hurley Hospital;**
- **Regional neonatal intensive care unit at E. W. Sparrow Hospital serves mid-Michigan patients and is staffed by full time neonatologist from MSU. A similar intensive care program is supported in Saginaw through Saginaw Cooperative Hospitals, Inc.;**
- **Assistance in dealing with medical aspects of childhood handicaps for professionals in area school districts is provided in Muskegon, Newaygo, Oceana, Grand Rapids, Kent, and White Cloud Community schools;**
- **Primary health care for teenagers under the auspices of the Michigan Department of Social Services in half-way houses in Lansing and Flint is provided by an adolescent health care team including full-time pediatric faculty, pediatric nurse practitioners, a psychologist, and a nutritionist, and**
- **Genetics clinics at Mott Children's Center in Flint and Grand Rapids' Butterworth Hospital are staffed by a geneticist, pediatrician, neurologist, nurse, social worker and a psychologist.**

MSU HEART / *Continued*

desperate cardiac condition, intra-aortic balloon counterpulsation (IABP) was added to the facilities of the heart program in September 1975. IABP proved reliable in improving or supporting myocardial performance in desperately ill patients; of 27 patients requiring its use, 23 survive. Furthermore, the facility was easily established in a community hospital where patients referred to such a service are often rejections from larger clinics and medical centers (five patients) or emergency situations (six patients).

Cardiac retraining program

The cardiac retraining program began two years ago at Ingham Medical Center. It is a multidisciplinary program whose purpose is active rehabilitation of the post-myocardial infarction patient, the post-coronary artery bypass patient, and selected coronary artery disease and anginal patients deemed by their attending physicians, cardiologists, and cardiac surgeon to benefit from a physical exercise program, as well as dietary and vocational counseling.

Once the patient has achieved the early goals of the intensive program, a home exercise program prescription is provided. The remainder of the first year, the patient is seen on a periodic basis to assure that he is maintaining or continuing to improve his program, as well as reinforce established goals. The most obvious benefit is not reflected in any statistics. The group activity draws the patient out and gives him a more positive attitude toward his future.

Comment

Most sophisticated care for heart disease is characteristically administered in large metropolitan centers often located a distance from small, as well as larger communities. The result is deprivation of such services for a number of patients. Hospitalization at distant institutions may cause additional medical, financial,

Table III

Cardiovascular Procedures

Category	1974	1975	1976	Total	Mortality (%)
Acquired Conditions					
Open Procedures					
Ischemic disease*	20(1)**	55(4)	80(3)	155(8)	5%
Valvular disease	18(2)	26(1)	30(1)	74(4)	5.4%
Closed Procedures	—	1	1	2	
Congenital Conditions					
Open Procedures	27(2)	30(5)	10(3)	67(10)	15%
Closed Procedures	3	10(1)	10	23(1)	4%
TOTAL	68(5)	122(11)	131	321	7.2%

*Includes those undergoing surgery for complications of myocardial infarction: ventricular aneurysms, ruptured papillary muscles and ventricular septal defect

**Denotes deaths ( )

and psychological burdens on the patient and his family. The physician and patient considering these factors must make an awesome decision that may end in procrastination.

The integration of university health care services with community facilities, if well organized, yields high-quality health care delivery where it is needed. Of course, struggles are apt to occur at the onset of such a project. At the risk of over simplification, one may take the view that the so-called frictions of "town and gown" are nothing more than the manifestations of interactions between two groups with disparity of objectives, aspirations, and interest. However, a certain commonality of goals can be ascertained and, if both parties involved are mature and cooperative enough to welcome the concept and work together, the development of a program such as ours is assured.

In the light of our experience, the following conclusions can be drawn: 1) high quality health care delivery can be offered near the patient's home with results comparable to those of large metropolitan medical centers; 2) contrary to some beliefs, this program is neither expensive nor cumbersome; 3) in addition to high quality patient care, the affiliation of the university and the community hospital enhances the educational programs, not only of the medical students and house staff, but also of all the hospital personnel and, most importantly, the community as a whole.

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Neurologists act on EEGs and CAT scans

At the most recent meeting of the Michigan Neurological Association, the members adopted two resolutions of interest and importance to the physicians and hospital administrators of this state.

First, regarding the *qualifications for interpretation of electro-encephalograms and supervision of electro-encephalographic laboratories*, the MNA resolved that the following individuals should henceforth be considered qualified to supervise an EEG laboratory and interpret EEG's:

1) Physicians who have certification in neurology by the American Board of Psychiatry and Neurology, Inc., or

2) Physicians who have been certified by the American Board of Qualifications in Electroencephalography (the qualifying board affiliated with the American Electroencephalographic Society), or

3) Neurologists or neurosurgeons who are board-eligible (by the American Board of Psychiatry and Neurology, Inc., or the American Board of Neurological Surgeons) who, in addition have a statement from their residency program directors that they are qualified to direct an EEG laboratory and interpret EEG's.

Secondly, regarding *computerized axial tomography and related procedures,* the Michigan Neurological Association endorses and supports the stand published by the American Academy of Neurology, and the American Neurological Association, and the American Association of Neurological Surgeons regarding neuro-imaging procedures.

That stand is as follows:

Because neurologists have traditionally been concerned with neurodiagnostic procedures and their interpretation,

Because the advent of new techniques for imaging the brain and spinal cord, for measuring blood flow and neural function, are the greatest importance for care of patients with neurologic disorders and for teaching and research,

Therefore the Association wishes to emphasize that neurologists must be involved in the decision making, performance and interpretation of these procedures. Neurologists, must also be intimately involved with planning, implementation, and execution of programs designed to teach these new techniques to physicians, technicians, and students.

Meetings

(See also listing of Category I programs on page 496.)

Sept. 21-22 – Retreat, MSMS Auxiliary, Howard Johnson's, Grand Rapids, contact: Mrs. John McGinty, 38232 E. Horseshoe, Mt. Clemens, 48043.

Sept. 27-28 – Retreat, MSMS Auxiliary, Ramada Inn, Midland, contact: Mrs. John McGinty, 38232 E. Horseshoe, Mt. Clemens, 48043.

Sept. 29-30 and Oct. 1 — "Implant Surgery for Joints and Tendons in the Hand," sponsored by American Society for Surgery of the Hand, Blodgett Memorial Medical Center, Grand Rapids, contact: Blodgett Memorial Hospital, 616/774-7444.

Sept. 30 — Annual Meeting, Michigan Society of Internal Medicine, Hidden Valley Resort, Gaylord, held in conjunction with Michigan Regional Meeting, American College of Physicians, contact: John Kantner, Ingham County Medical Society, P.O. Box 770, East Lansing, 48823, 517/332-8021.

Oct. 7-8 – Workshop, Michigan Joint Practice Commission, Hyatt Regency Dearborn, contact: Mert Scholten, MSMS headquarters.

Oct. 10-11 — First Ann Arbor Symposium on Biology of Special Senses in Aging, Institute of Gerontology, the University of Michigan-Wayne State University, contact: Dorothy H. Coons, Symposium, Institute of Gerontology, University of Michigan, 520 E. Liberty, Ann Arbor, 48109.

Oct. 18 — "How to Help the Hyperactive Child," School of Continuing Education and Community Services, Central Michigan University, Mt. Pleasant, contact: William Bocks, PhD, CMU, Mt. Pleasant, 48859, 517/774-3715.

Nov. 2 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS Director.

Nov. 8-9-10 — MSMS Annual Scientific Meeting, Hyatt Regency Dearborn, contact: Herb Auer, MSMS headquarters.

Dec. 4-7 — Interim session, AMA House of Delegates, Palmer House, Chicago.

Dec. 10-13 — Clinical Convention, American Medical Association, Miami.

Dec. 14 — MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS Director.

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Category I Courses

Michigan Medicine *each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351*

The following have been accredited directly by the AMA or by MSMS Commission on Continuing Medical Education:

Organizations:

Ann Arbor Psychiatric Association
Commission on Professional and Hospital Activities, Ann Arbor
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan State University College of Human Medicine, East Lansing
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Society of Anesthesiologists
University of Michigan Medical Center, Ann Arbor
University of Michigan School of Public Health
Wayne State University School of Medicine, Detroit

Hospitals:

Alma-Gratiot Community Hospitals, Alma
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med.Center, PC/Little Traverse Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie
Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Detroit-Macomb Hospital Association
Ferguson-Droste-Ferguson Hospital, Grand Rapids
Grace Hospital, Detroit
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo State Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital), Muskegon
Marquette General Hospital
McLaren General Hospital, Flint
Mercy Hospital, Port Huron
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Oakland Medical Center, Pontiac
Oakwood Hospital, Dearborn
Pontiac General Hospital, Pontiac
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Edward Sparrow Hospital, Lansing
Traverse City State Hospital, Traverse City
V. A. Hospital, Battle Creek
Wayne County Psychiatric Hospital, Eloise
West Shore Hospital, Manistee
Ypsilanti State Hospital, Ypsilanti

Date: Sept. 14-17, **International Conference on Red Cell Metabolism and Function; Location:** Towsley Center, University of Michigan Medical Center, Ann Arbor; **Sponsor:** Office of Continuing Education, Department of PGM/HPE, U of M Medical Center; **For:** Hematologists, Internists, blood banking specialists; **Cost:** $100; **Contact:** G. J. Brewer, MD, Dept. of Human Genetics, Univ. of Michigan Medical School, Ann Arbor 48109; **Approved for:** 20 hours of Category I Credit.

Date: Sept. 16-18 — A Practical Course in Diagnostic Ultrasound. Location: Towsley Center, U of M Medical Center, Ann Arbor. **Sponsor:** U. of M Office of Continuing Education, Dept. of PGM/HPE. **Cost:** $125. **Contact:** Floyd C. Pennington, Ph.D., Director, U-M Office of Continuing Education.* **Approved for:** 16 hours of Category I Credit.

Date: Sept. 17, Role of Family in Psychosomatic Disorders. Location: Beaumont Hospital Auditorium, Royal Oak. **Sponsor:** Family Institute of Southeastern Michigan, **Co-Sponsor:** Beaumont Hospital Department of Psychiatry. **For:** Family Therapists. **Cost:** $25. **Contact:** Family Institute of Southeastern Michigan, North Park Plaza, Suite 1212, 17117 West Nine Mile Road, Southfield, 48075. **Approved for:** 5 hours of Category I Credit.

Date: Sept. 21, "What's New in Hyperalimentation — Parenteral, Enteral." Location: Kalamazoo Hilton. **Sponsor:** SMAHEC Family Medicine programs. **Cost:** $35. **Contact:** Donald E. DeWitt, MD, Coordinator, Family Medicine Residency, SMAHEC, 252 E. Lovell St., Kalamazoo, 49006. **For:** All interested physicians. **Approved for:** 7 hours of Category I credit.

Date: Sept. 23-25, Advances in Anesthesiology. Location: Sugar Loaf Village, Sugar Loaf Mountain, Cedar. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-Sponsor:** Michigan Society of Anesthesiologists. **Cost:** $125 for physicians, $70 for physicians-in-training. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education. **Approved for:** 10 hours of Category I Credit.

Date: Sept. 26-27, Accreditation and Conduct of Community Hospital Based CME; Location: Holiday Inn, Mt. Pleasant; **Sponsor:** Office of Continuing Education, Department of PGM/HPE, U of M Medical Center; **Co-Sponsor:** Michigan Hospital Association and the MSMS Commission on Continuing Medical Education; **For:** All interested physicians and educators; **Contact:** Susan Wright, Program Coordinator, 313/763-0200. **Approved for:** 8½ hours of Category I Credit.

Date: Sept. 26-28. Alcoholism and Drug Abuse for the Practicing Physician. Location: Detroit Plaza Hotel, Renaissance Center, Detroit. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $75 for physicians, $40 for physicians-in-training. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 15 hours of Category I Credit.

Date: Sept. 29-30, "Non-invasive Diagnostic Techniques in Cardiovascular Disease." Location: Borgess Hospital, Kalamazoo. **Sponsor:** Cardio-Vascular Services, Borgess. **Co-sponsor:** SMAHEC. **For:** All interested physicians. **Cost:** $60. **Contact:** Robin K. Norbe, Cardiovascular Services, Borgess Hospital, 1521 Gull Road, Kalamazoo, 49001. **Approved for:** 10 hours of Category I credit.

Date: Sept. 30 - Oct. 1, Respiratory Therapy Update. Location: The Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-Sponsor:** Michigan Society for Respiratory Therapy. **Cost:** $75. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 9¾ hours of Category I Credit.

Date: Sept. 30 - Oct. 2, Michigan Regional Meeting, American College of Physicians. Location: Otsego Ski Club, Gaylord. **Sponsor:** American College of Physicians. **Co-Sponsor:** Michigan Society of Internal Medicine. **For:** Internal medicine and related medical fields. **Cost:** $15, Non-members, $20. **Contact:** Beverly C. Payne, MD, Health Srvices Research Center, 220 East Huron Street, Ann Arbor, 48104. **Approved for:** 13½ hours of Category I Credit.

Date: Sept. 31-Oct. 1, Annual Medical Meetings, Seminars on Eye, Trauma, Gastroenterology, Cardiology. Location: Burns Clinic Medical Center, Petoskey. **Sponsor:** Burns Clinic. **For:** All specialties. **Cost:** $50. **Contact:** A. D. Damschroder, MD, chairman, Burns Clinic Medical Center, Petoskey, 49770. **Approved for:** 10 hours of Category I Credit.

Date: Oct. 4-6, Cardiology for Internists. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $170. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 22½ hours of Category I Credit.

Date: Oct. 5, Nutrition and Learning. Location: Mott Childrens Health Center, Flint. **Sponsor:** Mott Childrens Health Center. **For:** Pediatricians and family practitioners. **Cost:** $10. **Contact:** Gay Jennings, Hurley Medical Center, (313) 766-0283. **Approved for:** 5 hours of Category I Credit.

Date: Oct. 5, Gastroenterology for the Clinician. Location: Kalamazoo Hilton, Kalamazoo. **Sponsor:** Bronson Methodist Hospital Department of Gastroenterology. **Co-Sponsor:** SMAHEC. **For:** All specialties. **Cost:** $25. **Contact:** Charles L. Zeller, MD, SMAHEC, 252 E. Lovell, Kalamazoo 49006. **Approved for:** 5 hours of Category I Credit.

Date: Oct. 8, Clinical Day on "Low Back Pain." Location: Inservice Classrooms, Holy Cross Hospital, 4777 E. Outer Drive, Detroit. **Sponsor:** Holy Cross Hospital Medical Staff Education Committee. **For:** All specialities. **Cost:** $25. **Contact:** Kenneth K. Newton, M.D., Director of Medical Education, (313) 369-9100, ext. 2355. **Approved for:** 6 hours of Category I Credit.

Date: Oct. 11, Blood Coagulation for the Laboratory. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $50. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 7¼ hours of Category I Credit.

Date: October 12, Diseases of the Breast. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **Cost:** $50. **Contact:** Department of CME, St. John Hospital, (313) 881-8200, ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 12-14, Blood Coagulation for the Clinician. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $150 for physicians, $100 for Medical Technologists. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 17½ hours of Category I Credit.

Date: Oct. 13-14, Annual Conference, Organization of Michigan College Health Associations. Location: Albion College. **Sponsor:** American College Health Association. **For:** All interested physicians. **Cost:** $17 for members, $20 for non-members, $14 for students. **Contact:** Sandra Meeks, RN, 313/973-3478. **Approved for:** 7 hours of Category I credit.

Date: Oct. 13-15, Scientific Seminar and Alumni Meeting, Henry Ford Hospital Medical Association. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Medical Alumni Association. **For:** HFH medical alumni. **Cost:** $50 for physicians, $25 for house officers. **Contact:** Jeanette Asher, Henry Ford Hospital, (313) 876-1034. **Approved for:** 16 hours of Category I credit.

Date: Oct. 14-15, Medical and Surgical Aspects of Gastrointestinal Disease in Infants and Children. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $90. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 11 hours of Category I Credit.

Date: Oct. 17-21, Family Practice Review I. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-Sponsor:** Michigan Academy of Family Physicians. **Cost:** $250 for physicians, $125 for physicians-in-training. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 37 hours of Category I Credit.

Date: Oct. 22, "Manifestations of Systemic Diseases in Sub-Specialties." Location: Inservice Classrooms, Holy Cross Hospital, 4777 E. Outer Drive, Detroit. **Sponsor:** Holy Cross Hospital Medical Staff Education Committee. **For:** All specialties. **Cost:** $25 for staff members; $35 for non-staff members. **Contact:** Kenneth K. Newton, MD, Director of Medical Education, (313) 369-9100, ext. 2355. **Approved for:** 6 hours of Category I Credit.

Date: Oct. 24-25, The Sibley W. Hoobler Symposium: Causes, Management and Control of Hypertension. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $100 for physicians, $55 for physicians-in-training. **Contact:** Floyd C. Pennington, PhD, U-M Office Intramural Education.* **Approved for:** 10¼ hours of Category I Credit.

Date: Oct. 27-29, Plastic Surgery in General Surgical Practice. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education. **Cost:** $150 for physicians, $75 for physicians-in-training. **Contact:** Foyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 15½ hours of Category I Credit.

Date: Oct. 28, Clinical Symposium on Management of Coagulation Problems. Location: Ingham Medical Center, Lansing. **Sponsor:** Ingham Medical Center, Department of Medicine. **Co-Sponsor:** Michigan State University College of Human Medicine. **For:** All specialties. **Cost:** $25. **Contact:** Maryanne Hollandsworth, Department of CME, IMC, 401 W. Greenlawn, Lansing, 48910, (517) 374-2107. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 1, Symposium on Colon Rectal Cancer. Location: Saint Mary's Hospital, Grand Rapids. **Sponsor:** Saint Mary's Hospital, Grand Rapids. **Co-Sponsor:** Ferguson-Droste-Ferguson Hospital. **For:** All specialties. **Contact:** Harold E. Bowman, MD, Director of Pathology, Saint Mary's Hospital, 200 Jefferson SE, Grand Rapids, 49503. **Approved for:** 6 hours of Category I Credit.

Date: Nov. 2, "Current Therapy of Infectious Disease." Location: Kalamazoo Hilton Inn. **Sponsor:** Michigan Academy of Family Physicians. **Co-sponsor:** SMAHEC. **For:** All interested physicians. **Cost:** None. **Contact:** Joe Alberding, Portage Medical Clinic, P.C., 225 E. Centre St., Portage 49081. **Approved for:** 7 hours of Category I credit.

Date: Nov. 3-4, "Progress in Cardiology." Location: Borgess Hospital, Kalamazoo. **Sponsor:** Borgess Cardiology Dept. **Co-sponsor:** SMAHEC. **For:** All interested physicians. **Cost:** $60. **Contact:** Robin K. Norbe, Cardiovascular Services, Borgess Hospital, 1521 Gull Road, Kalamazoo, 49001. **Approved for:** 10 hours of Category I credit.

Date: Nov. 4-5, Twenty-Fifth Annual Symposium on Trauma; Location: Harper Hospital, Second Floor Webber Wing, 3990 John R, Detroit; **Sponsor:** Michigan Committee on Trauma of the American College of Surgeons; **Co-Sponsor:** Wayne State University Department of Surgery; **For:** All interested physicians; **Contact:** Joseph L. Posch, MD, Chairman, 1408 Kales Building, Detroit, 48226, Ph: (313) 962-0727; **Approved for:** 9 hours of Category I Credit.

Date: Nov. 4-5, Developmental Knowledge and Its Practical Application. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $60. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 10¼ hours of Category I Credit.

Date: Nov. 5, Laboratory Aids in Diagnosis. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All specialties. **Cost:** $50. **Contact:** Henry Ford Hospital, Medical Education Office, (313) 876-1464. **Approved for:** 7½ hours of Category I Credit.

Date: November 8-10, MSMS Annual Scientific Session. Location: Hyatt Regency Dearborn. **Sponsor:** MSMS Committee on CME Programming. **For:** All specialties. **Contact:** Herbert Auer, MSMS Department of CME Programming. (517) 337-1351.

Date: Nov. 9, Cardiology for Family Physicians. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-Sponsor:** Michigan Academy of Family Physicians. **Cost:** $60. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 7 hours of Category I Credit.

Date: Nov. 11-12, Mammography. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $60. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 9½ hours of Category I Credit.

Date: Nov. 16 — Diseases of the Biliary Tract. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** All specialties. **Contact:** Department of CME, St. John Hospital, Detroit (313) 881-8200, ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 17, Psycho-Pharmacology. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $60. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 7 hours of Category I Credit.

Date: Nov. 26-30 — Ophthalmology Review. Location: Dearborn Inn. **Sponsor:** WSU-Department of Ophthalmology. **For:** Ophthalmologists. **Cost:** $350. **Contact:** WSU Division of CME, Room 1209 Scott Hall, 540 East Canfield, Detroit 48201. **Approved for:** 40 hours of Category I Credit.

Date: Dec. 2, Care of the Burned Patient. Location: Towsley Center for Continuing Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-Sponsor:** University of Michigan Burn Center and National Institute for Burn Medicine. **Cost:** $15. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 6¾ hours of Category I Credit.

Date: Dec. 10 — "Needle Aspirations" Seminar. Location: University of Michigan, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** John F. Dunkel, MD, Department of Pathology, Michigan State University, East Lansing 48823 or James W. Landers, MD, Department of Pathology, St. John Hospital, Detroit. **Approved for:** 3 hours of Category I Credit.

Continuing Courses

Date: Continuing Quarterly Journal Club — Surgery; Location: Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Surgeons; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Monthly, Cleft Palate Clinic. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital****. **For:** Oral Surgeons, plastic surgeons, pediatricians. **Cost:** None. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 3 hours of Category I Credit.

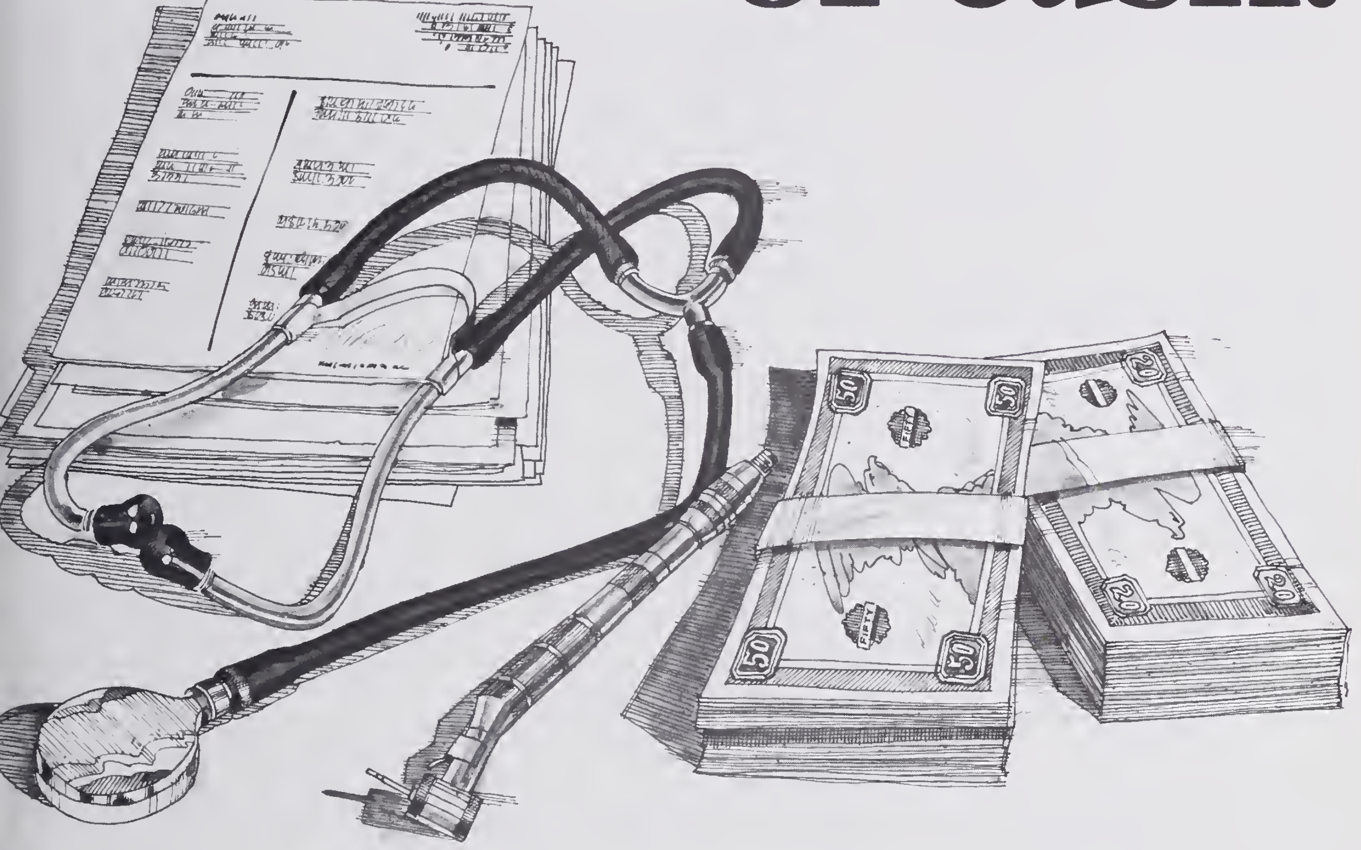
Date: Monthly, Tissue Audit (Cancer). Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Surgeons, ob-gyns, pathology, radiology. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 2 hours per session Category I Credit.

Date: Monthly Lecture Series in Ophthalmology; Location: Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Ophthalmogists; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Monthly, Ob/Gyn Journal Club. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** All in-

(Continued on page 500)

Receivables or cash?



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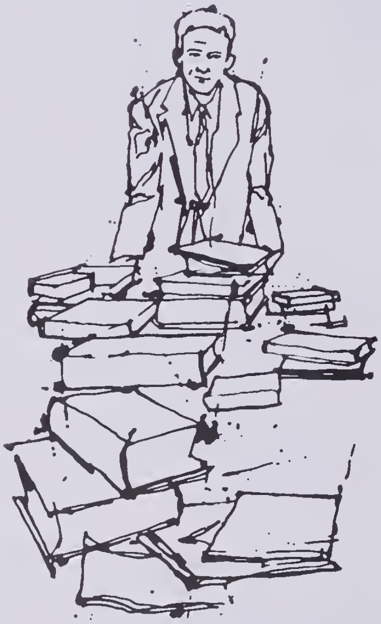
terested physicians. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category 1 Credit.

Date: Monthly Urology Journal Club; Location: Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Urologists; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital****; **Approved for:** 2 hours of Category 1 Credit.

Date: Begins September, Continuing Training in Family Therapy. Location: Suite 1212, North Park Plaza, 17117 W. Nine Mile Road, Southfield. **Sponsor:** Family Institute of Southeastern Michigan. **Co-sponsor:** Ackerman Institute. **For:** Psychotherapists. **Cost:** Varies according to time put in. **Contact:** Carolyn R. Tourkow, MSW, director, Family Institute of Southeastern Michigan. **Approved for:** Hours vary with time spent.



Date: Every Tuesday — Psychiatry — Special Problems Seminar; Location: Sinai Hospital of Detroit; **Sponsor:** Sinai Hospital; **For:** Psychiatrists; **Cost:** No charge; **Contact:** Office of CME, Sinai Hospital****; **Approved for:** 2 hours of Category 1 Credit.

Date: Every Tuesday morning, Gynecology/Obstetrics Combined Grand Rounds. Location: Jackson Auditorium, Hutzel Hospital. **Sponsor:** Wayne State University Department of Gynecology-Obstetrics. **For:** All interested physicians. **Cost:** No charge. **Contact:** Wayne State University, Division of CME**. **Approved for:** 4 hours each of Category 1 Credit.

Date: Wednesdays, Sept. 14 - Nov. 16, Cardiology Seminars. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** All specialties. **Cost:** $200. **Contact:** Department of CME, St. John Hospital, (313)881-8200, ext. 321. **Approved For:** 2 hrs per session hours of Category I Credit.

Date: Thursdays, Sept. 15 - Nov.17, Nuclear Medicine in Clinical Practice. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** All Specialties. **Cost:** $200. **Contact:** Department of CME, St. John Hospital, (313)881-8200, ext. 321. **Approved for:** 2 hrs per session hours of Category 1 Credit.

Date: Each Wednesday, Detroit Medical Center Hand Conference. Location: Classroom 3, Second Floor, Webber Wing, Harper Hospital, Detroit. **Sponsor:** Wayne State University. **For:** Surgeons. **Cost:** No charge. **Contact:** Joseph L. Posch, MD, Fourteenth Floor, Kales Building, 76 W. Adams, Detroit 48226. **Approved for:** Hour-for-hour Category 1 credit.

Date: Second Thursday of each month, Inter-Hospital Pathology Slide Conference. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** Pathologists. **Cost:** No charge. **Contact:** Department of CME, St. John Hospital, 22101 Moross Road, Detroit, 48236, (313) 881-8200. **Approved for:** 3 hrs. each date Category 1 Credit.

Date: Saturdays — Intermediate Training in Family Therapy. Location: Northland Clinic, Southfield. **Sponsor:** The Family Institute of Southeastern Michigan. **Co-Sponsor:** Ackerman Family Institute of New York. **For:** Psychiatrists. **Cost:** $25 per session. **Contact:** Carolyn R. Tourkow, MA, MSW, Suite 1212, North Park Plaza, 17117 West Nine Mile Road, Southfield 48075. **Approved for:** 3½ hours of Category I Credit.

Date: Saturdays, Morbidity and Mortality Conference. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital Department of Surgery. **For:** Surgeons. **Cost:** None. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 2 hours of Category 1 Credit per session.

Date: Every Saturday, Weekly Conference. Location: Gamble Building, Burns Clinic/Little Traverse Hospital, Petoskey. **Sponsor:** Burns Clinic/Little Traverse Hospital. **For:** All interested physicians. **Cost:** None. **Contact:** Ernest W. Carpenter, MD, 560 West Mitchell, Petoskey, 49770.

Date: Every Saturday, Weekly Conference. Location: Gamble Building, Burns Clinic / Little Traverse Hospital, Petoskey. **Sponsor:** Burns Clinic. **For:** All interested physicians. **Cost:** None. **Contact:** A. D. Damschroder, MD, Chairman, Burns Clinic Medical Center, Petoskey, 49770. **Approved for:** Hour-for-hour Category 1 Credit.

Date: Saturdays, Intensive Training in Family Therapy. Location: Southfield. **Sponsor:** The Family Institute of Southeastern Michigan. **Co-Sponsor:** Ackerman Family Institute of New York. **For:** Psychiatrists. **Contact:** Carolyn R. Tourkow, MA, MSW, Suite 1212, North Park Plaza, 17117 West Nine Mile Road, Southfield, 48075.

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*Office of Intramural Education, University of Michigan Medical Center, Dep't. of PGM/HPE, Ann Arbor, 48109

**WSU Division of CME, Room 1209, Scott Hall, 540 E. Canfield, Detroit, 48201 (313) 577-1453

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902

****Department of CME, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 272-6000

In Memoriam

Angus G. Goetz, MD
Grosse Pointe Farms

Angus G. Goetz, MD, Grosse Pointe Farms, died July 24 at the age of 80. A graduate of the University of Michigan Medical School, the orthopedic surgeon was awarded in 1972 the U-M Distinguished Alumni Award for outstanding leadership qualities, pioneering contributions in teaching of orthopedics and services to his fellow men. He was a member of the American Academy of Orthopedic Surgery, Clinical Orthopedic Society, and Orthopedic Guild.

Clarence N. Jaekel, MD
Grosse Pointe Farms

Clarence N. Jaekel, MD, retired general practitioner, died July 9 at the age of 81. Doctor Jaekel, of Grosse Pointe Farms, was on the emeritus staff of the department of surgery at Providence Hospital and was an honorary staff member of Holy Cross Hospital. A graduate of St. Louis University School of Medicine, Missouri, he was a fellow in the International College of Surgeons.

Hugh M. Mahoney, MD
Grosse Pointe Park

Hugh M. Mahoney, MD, former chief of staff and chief of surgery at Detroit Memorial and South Macomb hospitals, died July 13 at the age of 73. Doctor Mahoney, of Grosse Pointe Park, was a graduate of the University of Michigan Medical School. He lived and practiced in the Detroit area for 50 years before retiring recently. He served as medical director of the *Detroit News* for 30 years and was a member of the American College of Surgeons, as well as the Detroit Academy of Surgery.

Wilmer Freeman, MD
Birmingham

Wilmer Freeman, MD, Birmingham physician, died at the age of 71 on July 2. Doctor Freeman, who graduated from Wayne State University School of Medicine, was a founding member of North Detroit General and was a member of its board of trustees. The surgeon was a member of the American Society of Abdominal Surgeons and was also a fellow of the International College of Surgeons.

Robert T. Ewing, MD
Monroe

Robert T. Ewing, MD, Monroe, died June 25. He was 80. Doctor Ewing, a general practitioner, was a graduate of the Ohio State University College of Medicine, and was affiliated with Monroe Hospital, Monroe. He served in the military during World War I.

Ormond D. Geib, MD
Euclid, Ohio

Ormond D. Geib, MD, of Euclid, Ohio died on May 21 at the age of 81. Doctor Geib graduated from Wayne State University School of Medicine and was a staff physician at Coldwater State Home and Training School. He was a sergeant in the medical corps during World War I.

Amniotic fluid infection leading infant mortality cause

The U.S. infant mortality rate — regarded as one indicator of the health of the U.S. population — has been improving steadily since World War II.

In 1975 infant mortality rate was 16.1 per 1,000 live births. This represents a 44.9 percent decrease from 1950, when the rate was 29.2

But medical science is far from satisfied with the gains, and research continues on many fronts to try for even lower rates.

One such study — seeking to catalog the causes of deaths between 20 weeks of gestation and 28 days after birth — is the Collaborative Perinatal Project organized by the National Institute of Neurological and Communicative Disorders and Stroke.

The study sought to identify underlying causes of death in 53,518 pregnancies in the United States, in 12 university-affiliated hospitals in different regions between 1959 and 1966.

The leading cause of death (17 percent) was acute amniotic fluid infection, causing pneumonia in the unborn or newborn. Second leading cause (11 percent) was premature detachment of the placenta prior to birth. Premature rupture of the membrane caused 10 percent of the deaths, and nine percent were attributed to inherited defects. A variety of causes were assigned in the others.

Classified

ATTENTION CURRENT PEDIATRIC RESIDENTS: Our busy three-man pediatric practice will need another pediatrician in January, 1978 when one of us leaves practice for more training. We are on the teaching staff of Children's Hospital of Michigan in Detroit. In addition, we are located 30 minutes from the University of Michigan in Ann Arbor. We are seeing almost 100 newborns per month in a rapidly growing area. We take six (6) weeks of paid vacation per year, and have an excellent night coverage arrangement. We are prepared to offer a generous salary plus incentive bonuses, as well as excellent fringe benefits to the right person. Please contact Marshall J. Blondy, MD, 313/478-2739, if this offer is interesting to you.

ASSOCIATE MEDICAL DIRECTOR — most prestigious medical department in insurance industry seeking licensed physician. Excellent working conditions, 4½-day week, attractive fringe packages, highly desirable mid-sized, midwest city. Basic responsibility to provide medical opinions. Experience in internal medicine or family practice preferred. Reply Box 4, ℅ MSMS or call 219/749-5531.

OB-GYNE — WE ARE SEEKING a board certified or eligible physician to replace an OB partner lost because of health reasons. We are a 20-physician, multi-specialty group located 55 miles northwest of Chicago in the Chain-O-Lakes resort area with easy access to the city. Our candidate will step into an active three-man practice with incentive pay from day one (with a guaranteed minimum draw), malpractice paid, excellent fringe benefits. Our group is physically adjacent to a 144-bed general community hospital and state trauma center. Call or write Jim Dickson, McHenry Medical Group, 1110 North Green Street, McHenry, Ill 60050 — 815/385-1050.

FAMILY PRACTICE OPPORTUNITIES

Health Central, Inc., a new pre-paid group practice in Lansing, expects to open in late 1977. Plans call for primary care to be provided by family practitioners and nurse clinician/practitioners. NEEDED NOW is an experienced FP to act as a nucleus for a potentially large FP department. Salary in range of $50,000/year plus generous fringe benefits. For further information write or call:

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Telephone: (517) 332-6567

FULL-TIME ASSOCIATE DIRECTOR — Position of Assistant or Associate Director available to fill 3rd full-time faculty position in well established 9-year old Family Practice Residency program in Mid-Michigan.

Faculty appointment and affiliation with Michigan State University College of Human Medicine available. Salary commensurate with training and experience, excellent fringe package.

Strong point of this community based program is its excellent community involvement of Family Physicians and traditional specialists dedicated to a teaching program. Soon moving to all new ambulatory care center.

Should be Board Certified. Full complement of 24 residents. Duties would be resident and 3rd and 4th year medical students teaching and supervision. Minimal administrative duties.

Michigan is a water wonderland with all winter and summer sports readily available. 150 miles of best skiing in the midwest.

Contact: Robert J. Toteff, MD, Director, Family Practice Residency, 705 Cooper Street, Saginaw, Michigan 48602.

THIRD BOARD CERTIFIED OR BOARD ELIGIBLE PEDIATRICIAN needed for busy Pediatric group. Superb school system and year-round recreations, stable economy. Full staff privilege in teaching medical center. Contact: Alan Siegel, MD, 515 Lakeside Drive, SE, Grand Rapids, MI 49506.

MEDICAL DIRECTOR — REHABILITATION CENTER — Immediate opening. Thirty-bed inpatient rehabilitation center serving Southwestern Michigan. Located in a metropolitan community of 125,000; excellent schools; home of the cereal industry and good recreational facilities.

Responsible for organization and delivery of medical supervision to inpatients, working with medical and paramedical specialties in established in- and outpatient clinics and serving as clinic chief in certain clinics.

The director will be responsible, in collaboration with the medical staff and the medical care appraisal committee, for monitoring medical standards of the center; serve as a liaison with the local and regional community and provide medical direction of the center's programs.

Requires physician licensed to practice in Michigan and preferably certified or Board-eligible in a primary care specialty. Salary negotiable.

Direct inquiries to: SEARCH COMMITTEE, Southwestern Michigan Rehabilitation Center, Inc., 183 West Street, Battle Creek, MI 49017. Tel: 616/965-6315.

FOR SALE — Beautiful rustic hunting/summer cabin in Eastern Upper Peninsula, two bedrooms, sleeps ten, full fireplace, completely furnished, includes 140 acres of hardwoods and 20 acres of pine tree plantation, good access, hot sauna, surrounded by State Forest, good investment, inquire Box 412, Newberry, MI 49868.

PSYCHIATRIST-BOARD ELIGIBLE OR BOARD CERTIFIED — wanted for full-time employment as Medical Director in a community Mental Health Center serving a four-county population of approximately 60,000.

In addition to regular psychotherapy and medical responsibilities, this position requires the coordination and supervision of treatment programs of the Center.

We are located in Michigan's beautiful Upper Peninsula Copper Country, consisting of small communities and surrounded by excellent outdoor recreational facilities.

The Center is certified by the Michigan Department of Mental Health and is funded primarily by State and local governmental monies.

Salary negotiable. All applicants must have or be eligible for a Michigan Medical license. Contact: Earl F. Ex, C. S. W. Director, Copper Country Mental Health Center, P. O. Box 47, Houghton, MI, 49931, 906/482-2212.

FOR SALE — used Picker Radiographic and Fluoroscopic X-ray System, including single phase 4-socket transformer, citation table with 17-14 spot film device, 6-inch image intensifier, ceiling tube mount, PX35 tube, collimator, linear tomographic system, 90-second automatic processor and dark room accessories. Call P.D. Iveson, 313/557-4440.

PHYSICIAN NEEDED for directorship of Midland County Health Department. Requirements: licensed in practiced medicine or osteopathy in Michigan. Salary commensurate with experience — range $36,000 to $42,000. Send resume to: Doctor Roy M. Goethe, Midland County Health Department, 237 Main Street, Midland, MI 48640.

OB/GYN, certified American Board, FACS, ACOG, 62, desires clinical position, full time, in Detroit metropolitan area or Down River. 313/282-2967.

FOR RENT — MEDICAL SUITE — Reception room, business office, private office, two treatment rooms, lab and restroom. Excellent location: 15 Mile Road, west of Gratiot. Contact: Charles C. Milonas, DDS, 313/791-1600.

SCHUSS MOUNTAIN CHALET — Picturesque chalet on wooded lot at Schuss Mountain Resort. Four bedrooms, wet bar with charcoal grill, etc., 1,750 square feet. Present owner has had an average rental income of approximately $2,500 per year. $60,000. Phone 313/729-2300; evenings 313/278-9806.

FOR SALE: 12,000 square foot doctor's office close to Mt. Clemens General Hospital. Building is modern and fully equipped in all rooms for medical practice. The present owner is retiring, with possession immediate. Down payment is negotiable and sale would be by land contract. For further information contact: Apples Real Estate, 313/979-6200.

HEMATOLOGY TECHNICIAN — am relocating in Michigan the end of September. Seeking employment in doctor's office, or small lab. Can do venipuncture, manual methods of WBC, RBC, hemoglobin determination, urinalysis, differentials and have basics in EKG and various other tests. Contact: Janice Kerzner, 65 Alber Marle Avenue, Hempstead, New York 11550, ph: 516/489-0570.

MEDICAL OFFICE SUITE — All new medical center in prime location of Brighton. 1350 square feet, four exam rooms, private office and entrance, laboratory, excellent parking, ideal to accommodate one or two doctors. Immediate occupancy. Call Davis Professional Building 313/229-2752 or 313/229-7525.

POSITIONS AVAILABLE. For the Lansing office, two internists and one Psychiatrist — For Traverse City, a part time or full time Internist — and for Oak Park, one Internist and possibly one Psychiatrist, — These physicians to be with the Disability Determination Program under Social Security Administration. Salary currently in high thirty thousands, plus 22% fringe benefits, including life, accident, long term disability and hospital and major medical coverage. An outstanding benefit is deferred compensation. Pension benefit after 10 years' service. Liability insurance not necessary. 40 hour work week. No weekends or nights. 50 hours allowed for obtaining necessary CME credits. Vacation leave and sick leave is given. Position entails review of medical records, training and teaching of disability examiners, as well as some public relations. An equal opportunity employer. All enquiries treated confidentially. For further details, please write: Disability Determination Program, Box 30011, Lansing, Michigan 48909, OR call collect: Harry D. Nesmith, M.D., Chief Review Physician, (517) 373-7789.

ATTRACTIVE OFFICE SPACES now available for rent in the Muskegon Mall area. Located in the Medical Arts Plaza, 315 West Clay Avenue, Muskegon, Michigan. Reasonable rates with many modern conveniences. For further information please contact Mrs. Westerman, (616) 726-3641 or after 5:00 p.m. (616) 725-7120.

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Potpourri

By Herbert A. Auer, Executive Editor

Practical advice to help physicians become more effective as a political force was given at the recent MDPAC Workshop in Lansing by Douglas Bailey, of the political consulting firm of Bailey, Deardourff and Eyre. "It is too late to show up at the new congressman's office in January," he told the Michigan doctors. "It is better to be with him on election night — but better yet to be there during the primary — and still better to be there when the man decides to become a candidate."

* * *

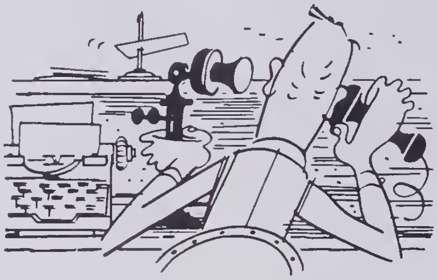
A recent issue of *Kiplinger Washington Letter* told its readers, "Your membership in an association is an investment. It is up to you to become involved and change things from within, if you don't like the return you are getting."

* * *

The AMA House of Delegates offers this advice to individual physicians: "Assume the leadership in developing an ongoing program of guidance, advice and strategy regarding the local HSA planning process, and develop a program to monitor and disseminate results of the HSA planning process."

* * *

Negative dynamics are working now as cities decline in population and growth. Urban planning experts now must consider lower birth rates, the growing number of elderly, greater numbers of single women and increasing disintegration of marriages. The remaining city dwellers likely will include the poorer, older and more minority-dominated — and single women. All of this was considered at a recent National Academy of Sciences meeting.



"There is always an easy solution to every human problem — neat, plausible and wrong." So writes Lawrence J. Peter in the *Peter Principle.*

* * *

Furnace repairmen talk about the rising costs of medical care, which was at 184.7 on the Consumer Price Index in 1976. Physicians talk about the rising costs of furnace repair work, 207.1 on the Consumer Price Index.

* * *

John D. Yeck, secretary of the Let's Have Better Mottoes Association says, "A bigot is a boss who thinks there's only one way a word can be spelt."

* * *

H. L. Mencken once wrote in *The American Scene,* "I am strongly in favor of common sense, common honesty and common decency. This makes me forever ineligible for any office of trust or profit in the Republic."

* * *

It is estimated that 60 percent of the world's four billion people are malnourished, physically underdeveloped and poorly educated.

"Everyone is as God made him . . . and oftentimes a good deal worse." — Miguel Cervantes.

* * *

At a recent American Newspaper Publishers Association meeting, Ruth Clark, senior vice president of a firm serving the publishing industry, observed that while Americans are getting more private freedoms there is a rising demand for censorship. She also predicted another contradiction, "We will see a strong public thrust for the maintenance of a free, unencumbered press — but guaranteed in the public's mind by all sorts of government regulations."

* * *

Have you read the book, "The Plug-in Drug"? That's the clever title chosen by Marie Winn to voice her philosophy about television. She contends the greatest hazard is that "while one is watching TV, one is not having any other experience." The author is deeply concerned that thousands of pre-school children every day spend a third of their waking hours watching television.

* * *

Peter Drucker in *The Man Who Invented the Computer* writes, "Medicare and Medicaid are the greatest inventions yet devised to make the world safe for clerks."

* * *

"The sue-somebody syndrome," declares the St. Paul Property and Liability Insurance Company in paid magazine ads, "has pushed the cost of provider liability insurance to record levels." The average settlement reportedly is 200 percent larger than five years ago. St. Paul says if the problem isn't solved, "you better keep your checkbook handy."

Michigan Medicine Contents

***Michigan Medicine*, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about contemporary issues and actions of the Michigan State Medical Society, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.**

MSMS headquarters

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Warren F. Tryloff, director

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The Publication Committee of the MSMS Council is the editorial board of *Michigan Medicine* and advises the Council and the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

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In the next issue . . .

MSMS white paper on national health insurance.

President's Page

Vernon V. Bass, MD
MSMS President

We must continue to protect our patients and their rights

I'm very pleased with the unanimous Council action to call a special session of the House of Delegates.

In my inaugural address I said we must debate the issues, offer a consensus and stand united. This is a crucial decision. I believe we must continue to be the protectors of our patients and their rights.

To collect money from the people without their say-so, to spend it on benefits without their say-so, to insist they go to a physician not of their choice, to accept a promised full-service contract reduced to meager benefits and partial pay because of cost containment, and to offer an increase in benefits without funds to pay for them is wrong — and markedly irresponsible of Blue Shield and Blue Cross. Is it a State of Michigan miniature-NHI or a giant HMO of Michigan?

Don't let the minutiae cloud the issue — the "par, non-par, specialists, non-specialists, small/large group area" designations. You must remember, you are the protectors of your patients' health and MSMS is the physician of Michigan citizens.

It is my belief we must protect them. The sacred right to have their own physician, to buy health insurance they can afford to protect themselves against loss if they desire, is their American freedom. Neither freedom nor morality must be sacrificed for a political expediency, financial gain, or cost containment.

I couldn't help but draw parallels while on a walk on my farm recently.

That Sunday began clear, bright and beautiful with a gorgeous sunrise. On a quiet walk I surprised three large buck deer having breakfast on my corn. Then, from a standing start, they made a jump over a four-foot fence with ease. A lead squirrel warned those in the trees and those on the ground gathering for winter's blast that I was an intruder on my own land. A partridge along the creek flew away through the woods — an impossible feat.

Members of MSMS, let us now formulate our consensus and stand firm. Read your mail, inform your delegates, let them know. Remember, no one can force you to do anything. You can only do it to yourself. Good luck!

So, let me again ponder the question of who ate my choice melons — the deer, the squirrels or raccoons? Does it matter? The melons have been eaten.

For more MSMS leaders' views of the Blues' new payment systems, see page 513.

Register now to ensure first choice at MSMS Scientific Meeting Nov. 8-9-10

Act now. There is still time to register in advance for the 1977 MSMS Annual Scientific Meeting, coming up fast Nov. 8-9-10 at the Hyatt Regency Dearborn.

"Because the hotel meeting rooms vary in size, we have had to establish maximum enrollments for the courses — so enroll now for your first choice," stresses Robert F. Wilson, MD, Wayne State University School of Medicine educator, program chairman. Registrations, of course, will be accepted at the three-day meeting.

Interest is high in the 50 practical half-day, Category I Credit courses to be taught during the three days by recognized Michigan and national physicians.

"The overall theme this year is 'Practical Advances in Patient Management.' We want to stress the practical aspects of everyday patient care," explains Doctor Wilson.

Registration forms and course information were sent to all physicians in September in *Michigan Medicine* and in the *Medigram,* and again in the early October *Medigram.* The registration form is printed on the last page of this issue of *Michigan Medicine* so it may be torn out easily and mailed to MSMS.

All the courses this year will provide three hours of Category I Credit for a nominal fee of $9 per course for members. The charge is $45 per course to non-members. Residents-in-training and interns may attend free of charge. Funds from MSMS dues are being used to cover the staff salaries and tuition is being charged to cover cash payments for speakers' honoraria and travel, printed program, publicity and postage.

The 50 courses have been developed by specialty societies, MSMS sections and by departments of the three Michigan medical schools. "We are so appreciative of the excellent cooperation we have received from the many practicing physicians and medical school educators who contribute their time and talent as course directors and instructors. There will be more than 200 physicians teaching during the three-day meeting," reports Doctor Wilson.

Physicians traveling to the Hyatt Regency Dearborn for the first time will find it handy off I-75, I-94 and I-96. The Hyatt Regency is the cornerstone of the large shopping center at the northwest corner of Michigan Avenue (US-12) and the Southfield Freeway. The meeting last year drew more than 2,000 physicians — and many spouses.

This ambitious project is under the overall supervision of the MSMS Committee for CME Programming, Carl F. Hammerstrom, MD, Marquette, chairman. The Committee has been accredited by the AMA to provide Category I Credit opportunities in Michigan.

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Meet the course directors for MSMS Scientific Meeting

Here are course directors and their topics:

Robert F. Wilson, MD
Scientific Meeting
Chairman

Anbe

Barrett

Beierwaltes

Borden

Buslepp

Campos

Casenas

Chapel

Conway

Coons

Davis

Dean

Edmond

Fink-Bennett

Frye

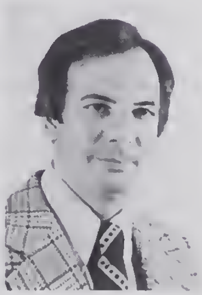
Gilroy

Hull

Isbister

Julius

Krystal

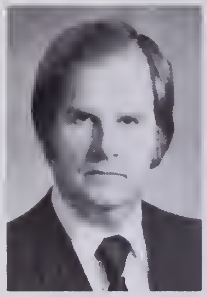


Lichter

Logsdon

Lowe

Mathog


Meester

Nowak

Olson

Petrilli

Piligian

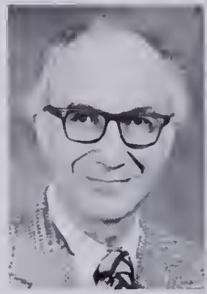
Port

Royer

Santinga

Schwarnweber

Sinkoff


Sklar

Spencer

Taber

Toteff

Turcotte

Vaitkevicius

Wade

Weg

Weil

Whitehouse

Wilcox

Wilson, D.

Wilson, N.

Photos of the other course directors were not available.

Tuesday Morning

Daniel T. Anbe, MD, Detroit
Basic Cardiac Life Support

William H. Beierwaltes, MD, Ann Arbor
Diagnosis and Treatment of Thyroid Disease

Dorothy Coons, Ann Arbor
Myths, Perceptions and Realities: Physiological Aspects of Aging

Zev Davis, MD, Detroit
Combined Medical and Surgical Approach to the Patient with Angina (Part I)

Carl M. Frye, MD, Ann Arbor
Myths, Perceptions and Realities: Physiological Aspects of Aging

Franklin E. Hull, MD, Detroit
Combined Medical and Surgical Approach to the Patient with Angina (Part I)

Stevo Julius, MD, Ann Arbor
Prevention of Cardiovascular Disease: Diagnosis and Treatment of Hypertension and Hyperlipidemia

Felix Madrid, MD, Detroit
What's New and Different in the Treatment of Arthritis and Related Conditions
(photo not available)

Robert H. Mathog, MD, Detroit
Practical Otolaryngology

Anthony Petrilli, MD, Detroit
Recognition and Management of Sexual Problems in Clinical Practice

Neal Wilson, MD, Detroit
Flap Surgery: Reconstruction Versus Blood Supply (Part I)

Tuesday Afternoon

Daniel T. Anbe, MD, Detroit
Basic Cardiac Life Support

Dorothy Coons, Ann Arbor
Treatment of the Elderly Patient:
Practical Medical Guides

Zev Davis, MD, Detroit
Combined Medical and Surgical Approach
to the Patient with Angina (Part II)

Richard E. Dean, MD, Grand Rapids
Advances in Nutrition for the Practicing Physician

Darlene Fink-Bennett, MD, Southfield
Why Wonder? Just Call Nuclear Medicine

Carl M. Frye, MD, Ann Arbor
Treatment of the Elderly Patient:
Practical Medical Guides

Franklin E. Hull, MD, Detroit
Combined Medical and Surgical Approach
to the Patient with Angina (Part II)

John L. Isbister, MD, Lansing
Environmental Chemicals in Office Practice

John A. Lowe, MD, Ann Arbor
Appropriate Use of Physician Time in
the Medical Audit Committee Function

John T. Piligian, MD, Detroit
Effective Utilization of Blood and Blood Products

J. Clyde Spencer, MD, Lansing
Radiation Therapy in Management of
Breast and Colorectal Cancer

Neal Wilson, MD, Detroit
Flap Surgery: Reconstruction Versus
Blood Supply (Part II)

Wednesday Morning

Daniel T. Anbe, MD, Detroit
Basic Cardiac Life Support

John Gilroy, MD, Detroit
Newer Developments in the Diagnosis and
Treatment of Epilepsy

Daniel Hollander, MD, Detroit
What's New and Different in Diagnosis and
Treatment of Peptic Ulcer Disease
and its Complications

Christopher Lee, MD, Detroit
Practical Advances in Management of
Pediatric Orthopedics

Walter D. Meester, MD, Grand Rapids
Management of Acute Poisonings and Overdose

Friedrich K. Port, MD, Ann Arbor
Advances in the Understanding and Treatment
of Acute and Chronic Renal Failure

George L. Royer, MD, Kalamazoo
Management of Acute Poisonings and Overdose

Jean Sinkoff, MD, Southfield
Health Problems of Children and Adolescents

Robert J. Toteff, MD, Saginaw
Improving Physician-Patient Communications
or How to Avoid Malpractice Suits

William B. Weil, Jr., MD, East Lansing
Management of the Multiple-Problem Child and
His Family, Focusing on Myelodysplasia

Kenneth R. Wilcox, MD, Lansing
Para-Phenomena of Influenza

Wednesday Afternoon

Daniel T. Anbe, MD, Detroit
Advanced Cardiac Life Support

Manuel M. Campos, MD, Grand Rapids
Colon and Rectal Surgery

Thomas A. Chapel, MD, Detroit
Practical Considerations in the Use
of Steroids and PUVA

Gerald F. Conway, MD, Royal Oak
Urinary Tract Infection: A Burning Issue

Paul R. Lichter, MD, Ann Arbor
What's New and Practical in the
Management of Glaucoma and Cataract

Nels R. Olson, MD, Ann Arbor
Latest Advances for the Specialist in Otolaryngology

John G. Weg, MD, Ann Arbor
Acute Bronchial Asthma — Pathophysiology
and Treatment

William B. Weil, Jr., MD, East Lansing
Management of the Multiple-Problem Child
and His Family, Focusing on Obesity

B. David Wilson, MD, Kalamazoo
Drug Allergy and Drug Related
Reactions and Their Management

Thursday Morning

Daniel T. Anbe, MD, Detroit
Advanced Cardiac Life Support

E. Keith Borden, MD, Kalamazoo
Adverse Reactions to Drugs as Related
to the Practicing Physician

Robert C. Buslepp, MD, Jackson
Problems of the Young Athlete

George L. Royer, MD, Kalamazoo
Adverse Reactions to Drugs as Related
to the Practicing Physician

H. C. Schwarnweber, MD, Midland
Special Problems in Treatment and
Rehabilitation of Burns and Injuries

Joseph Silva, MD, Ann Arbor
Newer Developments in the Diagnosis and
Treatment of Hospital-Acquired Infections

Rodman E. Taber, MD, Warren
Treatment of Symptomatic Coronary Artery Disease

(Continued on Page 512)

ANNUAL SCIENTIFIC MEETING / *Continued*

Robert J. Toteff, MD, Saginaw
Improving Physician-Patient Communications
or How to Avoid Malpractice Suits

Franklin V. Wade, MD, Flint
Perspicacious Evaluation of the
Patient with Multiple Injuries

Thursday Afternoon

Raymond J. Barrett, MD, Detroit
Carcinoma of the Lung

Emmanuel R. Casenas, MD, Detroit
Violence in the Family and New
Trends in the Management of Alcoholism

Elizabeth W. Edmond, MD, West Bloomfield
Manipulation and Mobilization in the Treatment
of Musculo-Skeletal Myofascial Pain

Henry Krystal, MD, Southfield
Violence in the Family and New Trends
in the Management of Alcoholism

Linda Logsdon, MD, Southfield
Violence in the Family and New Trends
in the Management of Alcoholism

Richard M. Nowak, MD, Detroit
Shock in Emergency Care: Prevention,
Recognition and Management of Organ Failure

John Santinga, MD, Ann Arbor
Exercise in the Diagnosis and Management
of Ischemic Heart Disease

Manuel Sklar, MD, Detroit
Management of Inflammatory Bowel Disease

Jeremiah G. Turcotte, MD, Ann Arbor
What's New in Surgery

V. K. Vaitkevicius, MD, Detroit
Role of the Practicing Physician in the
Treatment of Breast and Colon Cancer

Fred W. Whitehouse, MD, Detroit
Management Problems in Diabetes, 1977

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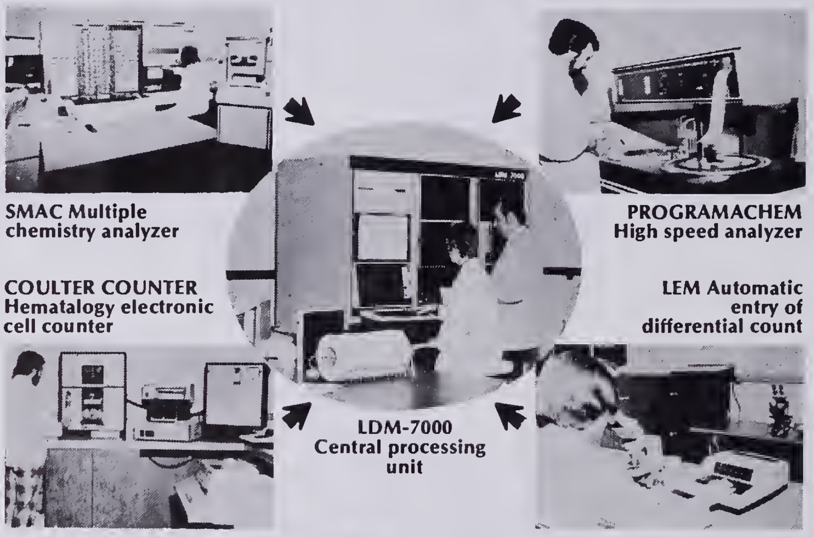
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Doctor Crandall

By Donald K. Crandall, MD
Chairman, MSMS Negotiations Committee

The Michigan State Medical Society played a role in developing Blue Cross/Blue Shield programs which have served the people of Michigan so well. However, over the past few years, the "Blues" have undergone significant change. They now are an unwieldy conglomerate of special interest groups making great demands on the health care system, with little concern for cost effectiveness of benefit packages.

With these increased benefit demands, have come increased utilization and increased cost for health care. During the past few years, MSMS has made several recommendations to the BCBSM organization on cost containment. These all have been rejected because they have been in conflict with one special interest within the BCBSM Board.

Full responsibility on MDs

Now, the BCBSM new Physicians Reimbursement Program places the entire responsibility of utilization control upon the physician, while consumers remain free of their equal responsibility to use reason in seeking services and in making demands for expanded benefits.

Blue Cross/Blue Shield is introducing three new programs which are of great concern to MSMS. The Society feels these programs are not in conformance with the "Enabling Act," as they attempt to influence a patient's free choice of physician through economic restraints.

In essence, MSMS believes Blue Cross/Blue Shield is attempting to develop a "closed list" of physicians from which patients must choose to receive full reimbursement for their medical services. This is accomplished in the new physician's reimbursement program; by failure to update a non-participating physician's screen and profile; a Vision Care Benefit Program, which will pay only 60% of non-participating physician's fees; and a Hearing Program which will reimburse the patient nothing for services rendered by a non-participating physician.

Another MSMS concern with the physicians reimbursement program is the "Target Limitation on Expenditures" proposal. Historically, physicians have been reimbursed for their services based on their "usual, customary and reasonable fees." BCBSM has abused the UCR system by failure to use current data in updating and compiling physicians' screens and profiles, and by capriciously placing artifical economic restraints and freezes on physicians' fees, while continuing to expand service benefits. The result is that physicians are forced to subsidize the increased demands and take the blame for increased utilization of medical services.

By setting "target limitations on expenditures," the Blues ultimately will eliminate the UCR system and will determine reimbursement levels on the rate of utilization. Physicians will have to deny medical services to be reimbursed at a reasonable level. This budget control on expenditures has been used effectively by the Medicaid system to control costs, with the result of significantly decreased payment levels to the physician for services.

MSMS has expressed great concern over these recent BCBSM policy changes. We have offered to work with BCBSM, the UAW, and the "Autos" to develop a system that addresses the *adequacy* of utilization. We again have offered to help develop a cost containment system that enlists both providers and consumers. BCBSM and the UAW apparently are not interested in the MSMS concern for cost containment with good medical care.

MDs have important choice

Physicians of Michigan have an important decision to make; will they remain free to select the medical care they deem necessary for the benefit of their patients, or will they submit to budget restrictions on the quantity and quality of care they offer?

I would hope all physicians in Michigan would individually withhold decisions regarding the BCBSM Programs until they are fully informed and can make their desperately needed input into a well-structured, functional health care delivery system that is responsive to the needs of our patients. In this way, we can guarantee our patients medicine will advance under the direction of health care professionals building on scientific fact and not under the direction of third-party interests who are politically motivated.

MSMS will hold a special meeting of the House of Delegates in late October to discuss these problems of such great concern. This meeting could well determine the future course of medicine in Michigan, and for that matter, the nation. I urge all physicians to become involved in these important deliberations.

Unity of MDs, patients, Blues, about to be destroyed

By James D. Fryfogle, MD
Speaker, MSMS House of Delegates

Doctor Fryfogle

In the beginning, the doctors of the State of Michigan created the Michigan Medical Service, "Blue Shield," so that the peoples of the State of Michigan could better finance their health care needs, and this was good. Throughout the approximately 35 years of its existence, doctors have supported and served in many capacities to make this form of financing a worthwhile benefit to their patients.

The State of Michigan, recognizing the need for such a fiscal organization, certified Blue Shield under an Enabling Act, that made it tax-exempt. This Act guaranteed to the citizens of Michigan freedom of choice of their physician, no interference in the patient-doctor relationship, and that their health care needs would be paid on a per-service basis.

New reimbursement policy

As of Oct. 1, 1977, and continuing in successive steps through the next few years, this unity of purpose between doctors, their patients, and the Blues is to be destroyed by Blue Shield's new reimbursement policy. Some patients who pay the same premium rate as others will be discriminated against, in that, the amount of monies paid for the covered services will be different, depending upon the physician they choose. For example: Two doctors may charge $20 for the same service. One may be a participating doctor in Blue Shield and one a non-participating doctor. If the patient goes to the participating doctor the $20 is paid by Blue Shield. If the patient chooses to visit the non-participating doctor, a lesser amount is paid for the same service, and the patient is responsible for the remainder of the bill. This is, frankly, a breach of contract between the third party payor and the subscriber.

The MSMS House of Delegates has voted for the last four years to make the payment of a covered service equal to all doctors throughout the State of Michigan. The Blues have divided the state into four geographic areas. The payment for the same service has been different in each of these areas. The House of Delegates was told by Blue Shield representatives that it would cost $4 million to equalize this payment throughout the state. Now, in their effort to gain complete control, — that is, to make all doctors participating physicians, the Blues are ready to spend $17 million of the subscribers' money to equalize payments as an incentive to make all physicians subject to the third parties' pricing policies.

The remaining features to be financed by this multimillion dollar war fund would allow physicians who participate to automatically receive a yearly adjustment of their fee profiles, even though they don't request it. This option will not be given to non-participating physicians. A one-time automatic adjustment to customary fee profiles for all those who participate or who will participate for the next 12 months is promised. A new raise in monies per service is promised if the physician will limit the number of services. This is done under the guise of utilization control, so that if you wish to receive the increased reimbursement for a service performed, you must deny your services to those patients who do not fit within your quota until another time frame presents. *This new Blues program seeks to manipulate physicians through a control of whom it will pay and how much.*

Lastly, the new visual care program sponsored by Chrysler and Ford Motor Companies, and managed by the Blues, has two startlingly different features. First, it is a *co-payment* program for eye examination and eye glasses, where the patient pays at least 20% of the bill. The Blues have long told us that "first dollar" coverage is the only way they can market a service program; while we, at every House of Delegates, have voted to incorporate a deductible feature that would vastly decrease the utilization of that service. But the Blues now wish to use this method again to direct their subscribers to which doctor they must go.

If the patient seeking an eye examination and glasses goes to a participating physician he is responsible for only 20% of the bill. If he goes for the same examination to a non-participating physician he is responsible for 40% of the bill. In the hearing program that is to follow, a portion of the bill will be paid to the patient utilizing a participating physician but *no payment* will be made to the patient utilizing a non-participating physician.

Unacceptable to MSMS

This entire program was passed by the Blue Shield Board with full knowledge that none of it was acceptable to The Council of the Michi-

(Continued on page 518)

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Final classification of the less-than-effective indications requires further investigation.

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Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily
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Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding

Parenteral administration is not recommended in the presence of hypotension or tachycardia

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

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Administration of single dose of 10 mg intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended Repeated administration of 5 to 10 mg intramuscularly at suitable intervals may be employed

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Doctor Adler

Blues trying to control soaring costs of their programs

By Sidney Adler, MD
Past President, MSMS and Michigan Medical Service

When Blue Shield started in 1941, it operated under what it called "fee schedules." They more properly should have been called "benefit schedules," putting a dollar amount of benefit on each procedure for which service coverage was provided. At the insistence of the profession, participating and non-participating physicians were treated alike. There were four schedules: one related to the lowest income portion of the population; one to the moderate income segment; one to a higher income segment, and the fourth to the highest income brackets. In the case of the first three, a physician who had agreed to participate was precluded from making an additional charge; in the case of the fourth, he was free to make an additional charge.

Blues begin to change

By 1963, the Insurance Commissioner and some labor and industry representatives were complaining that this system did not attract physicians to participate. In 1964, as a result of the litigation between Blue Shield (I was president at the time) and the Insurance Commissioner, a new contract was adopted under a consent judgment. It prohibited assignments from patients to physicians; and provided that in the case of participating physicians, payment should be made by Blue Shield to the physicians, and in the case of non-participating physicians, payments should be made to the patient. That allowed physicians who did not formally agree to participate to claim payment from Blue Shield, if in that particular case they were willing to accept the payment which they received from Blue Shield as full payment. Most physicians since have elected, in a large number of their cases, to accept the Blue Shield payment, although Blue Shield calls many non-participating.

In 1965 Congress passed the Medicare Act. That Act provided that the Medicare benefit for a physician's service should be a reasonable charge; a physician might take an assignment of the benefit from his patient and if he did, then he would be entitled to nothing more; if, however, he elected to bill his patient, the patient would be paid the Medicare benefit and would be responsible for the physician's charge.

Within a few years Blue Shield abandoned the fee schedule system and issued contracts under which the benefit was the amount of a reasonable charge (the so-called Michigan Variable Fee Contract). As a corollary, Blue Shield told the subscribers that if they became embroiled in a controversy with the physician over the amount of a reasonable charge, Blue Shield would defend its determination of the amount of the benefit for the service rendered. Blue Shield also told our societies that in the case of such disputes, the matter could be settled by peer review if the physician and patient were willing.

This did not satisfy a number of dissident physicians. They eventually succeeded in separating the societies entirely from the management of Blue Shield. While formerly the members of the Council and the officers of the State Society had been directors ex-officio of Blue Shield, they no longer sat in that capacity and represented only themselves. Individual physicians now represent only a small fraction of the total board.

Meanwhile, Blue Shield costs soared to astronomical levels under the reasonable charge system, because under that system Blue Shield to some degree could control its income, but could do little or nothing to control its outlays; the one was not dependent upon the other. That, apparently, is the problem that Blue Shield is trying to meet by its "cost containment" proposals. The trouble is that the proposed solution is no solution. It would put Blue Shield in control of medical practice and medical charges in the State of Michigan. The Commissioner, who controls Blue Shield's subscription fees, and thus its income would have the ultimate power over physicians' income and methods of practice.

Several proposals made

One of the proposals is that physicians sign a one year minimum agreement. A physician who would agree to be committed to receive whatever Blue Shield elected to give him for one year would be putting his professional fate into the hands of a group of laymen. Another proposal is to discriminate between the benefit to be paid for the services of participating and non-participating physicians. Such a proposal has been made from time to time over the past 35 years and the profession has opposed it as often as it has been proposed, by whomsoever proposed. Another proposal is to eliminate the differentials based on the geographical area in which the physician prac-

(Continued on page 518)

When **impotence** due to androgenic deficiency is driving them apart

Android® - 5 Buccal Tabs
Android® - 10 Oral Tabs
Android® - 25 Oral Tabs

Methyltestosterone U.S.P. – 5, 10, 25 mg.

New Double-Blind Study ANDROID-25 *vs.* Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy,* Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; + + = 50% improvement; + + + = 75% improvement. Placebo effectiveness was + or + + in 12.7% of trials. Android-25 elicited a +, + + or + + + response in 47.2% of trials. There was often a dose related response not observed with the placebo This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg . Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg . Postpuberal cryptorchism, 30 mg **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101 Medcom Press, N.Y., 1974 **HOW SUPPLIED** 5, 10, 25 mg. in bottles of 60, 250. Rx only

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ADLER/*Continued*

tices and the specialized training and experience of the particular physician. This is inconsistent both with the reasonable charge approach and the Medicare approach. Another proposal is that the benefit be a cost-plus benefit. To me, this would appear to be the wildest of all — to treat a learned profession in the same manner that a procurement officer would treat a supplier of blankets to the Armed Forces.

I also am offended by the constant reference in the Blue Shield materials to computer profiles and computer screens, as if somehow the computer, a mechanical monster, could have developed the ability to decide that which is a physician's reasonable charge. A computer should be a servant, not a master.

What is reasonable calls for the exercise of judgment, not of mechanical skill. I am quite happy to accept a reasonable charge for my services from any patient; in fact, I am quite aware that I cannot and should not expect anything more. I am quite unwilling to allow Blue Shield to tell me that I have to take something less. I trust that most of my colleagues are of the same opinion.

Most importantly, I am unwilling that my reasonable charge should be any more or any less because I have elected to become or not to become a participating physician; what is reasonable in the one case should be reasonable in the other.

FRYFOGLE/*Continued*

gan State Medical Society. In the Blue Shield letter of Aug. 17, sent to all Michigan physicians, it states that this program followed months of discussion between the Michigan State Medical Society, the Michigan Association of Osteopathic Physicians and Surgeons, and the Blues. *This is simply not true*. The only thing it should have said was that the Michigan State Medical Society objected to the program and that it was unacceptable to the practicing physician.

We now have a situation where financial incentives have been dangled in front of Michigan physicians to become full participating physicians in the Michigan Blue Shield program. The stand that Blue Shield has taken is one that for many years your House of Delegates has promoted as right and proper, — that is, equal pay for equal services in all parts of the state and a deductible co-insurance feature to decrease utilization. *BUT* Blue Shield has now incorporated these principles (which they formerly rejected) into a plan to give them complete control of fee setting for doctors' services.

I am calling a special meeting of the House of Delegates on October 26, at the Troy Hilton Hotel. The agenda will be limited to a full discussion of all aspects of this new physician reimbursement policy. A legal interpretation will be available for your consideration as to the misuse of the Enabling Act and price fixing aspects of this scheme. While I expect all Delegates to come to the House with full knowledge of the views expressed by the doctors they represent, I invite all physicians in the State of Michigan to come as a show of strength.

When the principles under which we labor are threatened, we stand together.

Statiscally, better than two-thirds of physicians' services are being paid by insurance. That is why we designed Medical Data Systems® to include computer preparation of insurance billings. Proven results have included significant reductions in personnel requirements and significant improvement in cash flow. MDS—tailored to meet the needs of group practices—large or small.

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Committee planning 1978 MSMS meeting

The MSMS Committee on CME Programming meets to consider co-sponsorship of coming medical meetings. At the head of the table is new chairman Carl F. Hammerstrom, MD, Marquette.

By Katie Brewbaker
MSMS Staff

The MSMS Committee on CME Programming has approved requests from four organizations asking the MSMS Committee to co-sponsor their events for Category I credit. Co-sponsorship of CME meetings with approved organizations is a developing function of the MSMS Committee.

Those groups are the Perinatal Association of Michigan; Michigan Joint Practice Commission; Michigan Hospital Association; Metropolitan Detroit Chapter, March of Dimes all of which have meetings planned this fall. (See page 526)

The CME Programming Committee has been authorized by the MSMS Committee on Accreditation Surveys to co-sponsor educational programs that meet Category I criteria. Interested component societies and medical specialty organizations may obtain application forms and details from the MSMS Committee on CME Programming, Box 950, East Lansing 48823.

The committee now is chaired by Carl F. Hammerstrom, MD, Marquette, who has succeeded John G. Wiegenstein, MD, Lansing, who resigned as Committee Chairman.

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Committee studies radiation bill

If Michigan's proposed Senate Bill 347 becomes law, hospitals and physicians could be charged with a misdemeanor and/or fined for failure to notify patients treated with ionizing radiation years ago!

SB 347 directs that certain hospitals, outpatient, clinics, and physicians that used radiation for therapeutic treatment of a patient must notify that patient (or patient's parent or guardian) by registered mail of "the type of radiation treatment given, the number of radiation treatments, the length of exposure of each radiation treatment, and the date of each radiation treatment"; this notification to be "accompanied by a recommendation that each patient undergo a physical examination for possible injury."

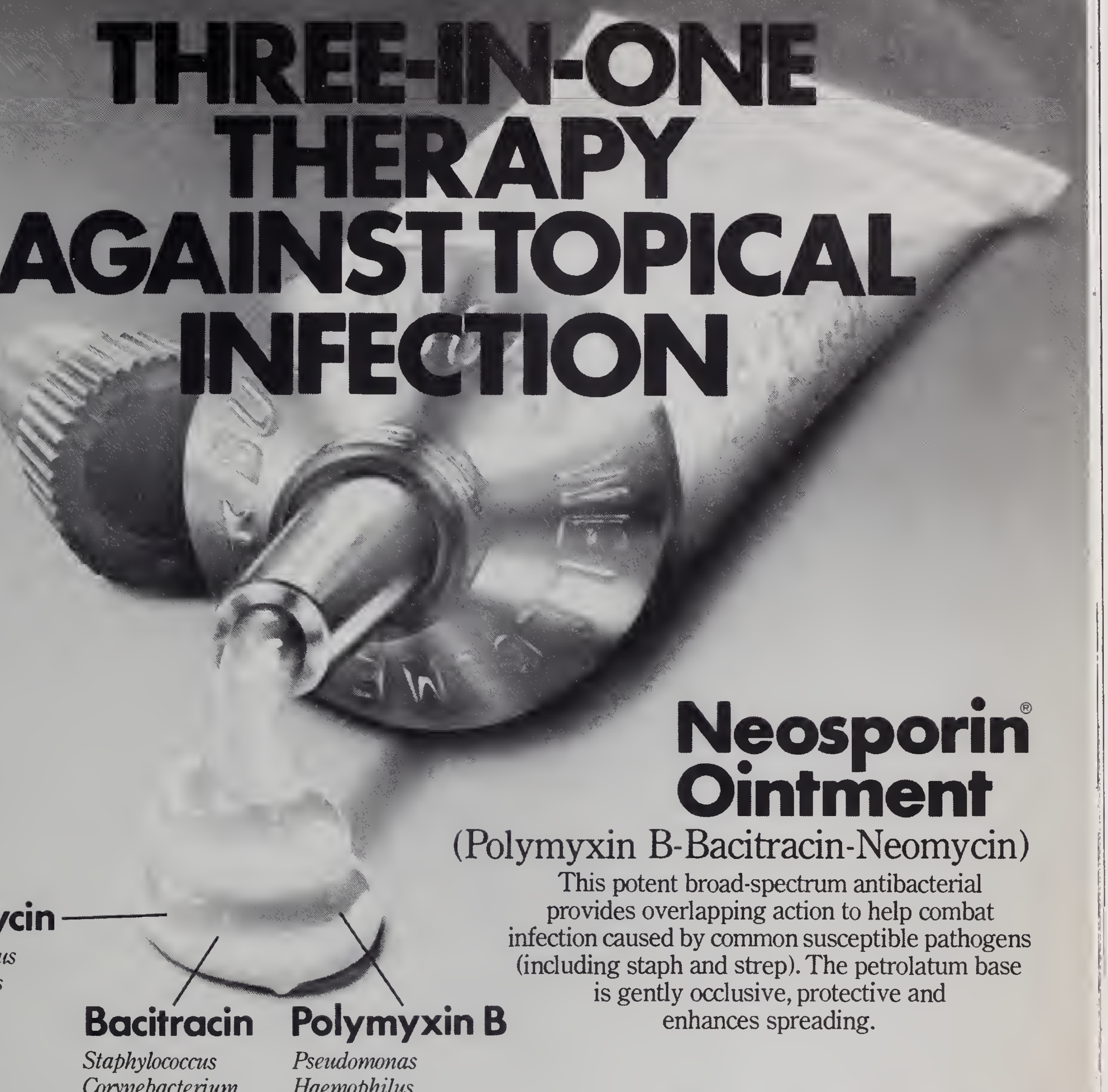
MSMS is actively opposing passage of this legislation, per the recommendation of its committees on **State Legislation and Regulations and Public and Environmental Health.**

It is the position of MSMS that compliance with SB 347 would be impossible. In many instances, hospital and physician records of patients who received the treatment specified in the bill no longer exist. If the records are available, most patients could not be reached because of changes in name and address. The cost in manpower to search records and attempt to locate these patients would be prohibitive and the yield almost nil.

MSMS believes an educational program to alert former patients of the potential danger of the treatment they received, and urging them to contact their physician, is a more effective and direct approach.

Your Committee on State Legislation and Regulations is working in cooperation with the Michigan Department of Public Health in the implementation of such an educational program for the public and for physicians.

For additional information regarding SB 347, contact the MSMS Division of Government Relations, Box 950, East Lansing 48823.



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In vitro overlapping antibacterial action of Neosporin® Ointment (polymyxin B-bacitracin-neomycin).

Neosporin® Ointment

(Polymyxin B-Bacitracin-Neomycin)

This potent broad-spectrum antibacterial provides overlapping action to help combat infection caused by common susceptible pathogens (including staph and strep). The petrolatum base is gently occlusive, protective and enhances spreading.

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(Polymyxin B-Bacitracin-Neomycin)

Each gram contains: Aerosporin® brand Polymyxin B Sulfate 5,000 units; zinc bacitracin 400 units; neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

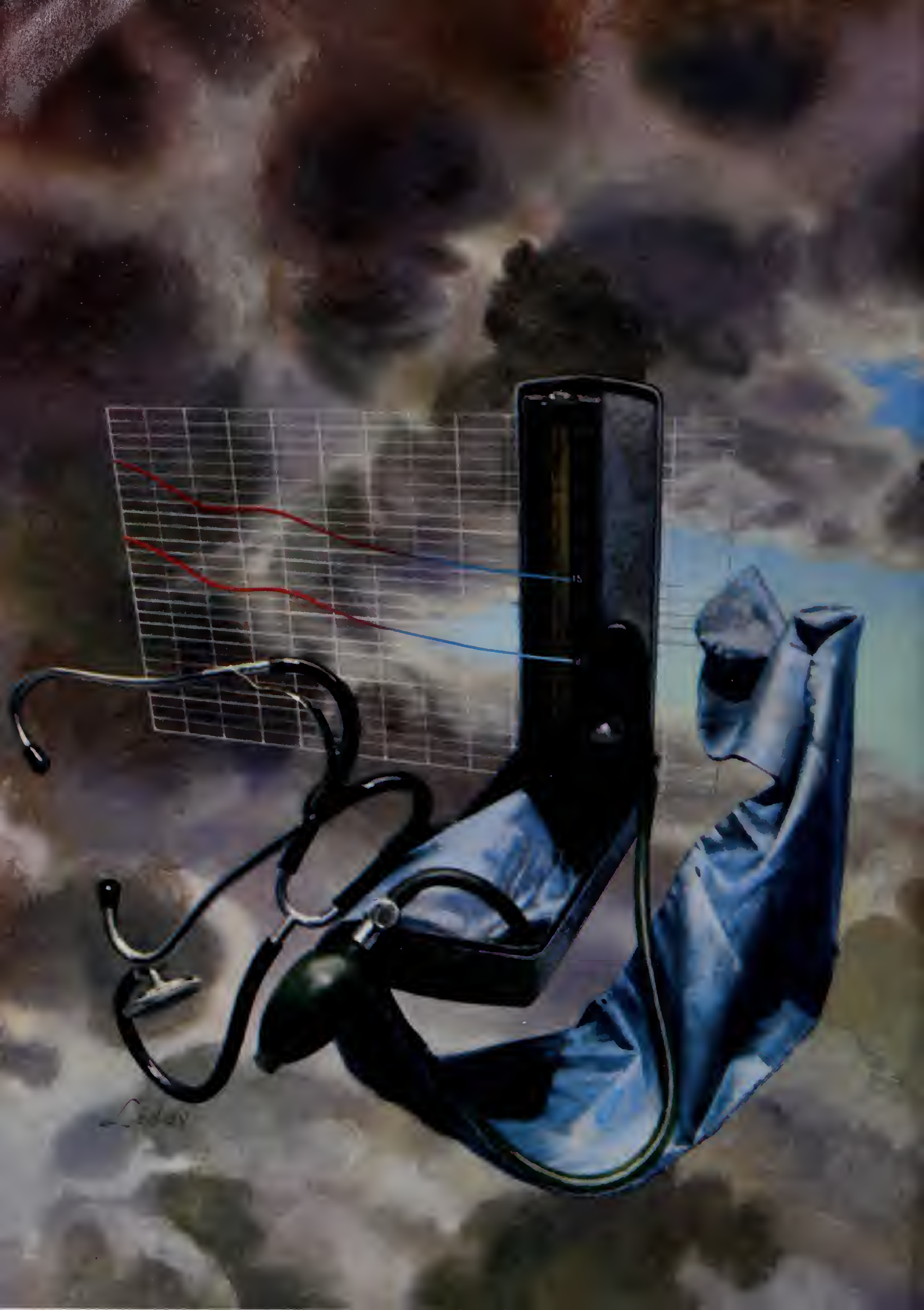
WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.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When choosing a diuretic for day-in-day-out hypertension control with comfortable compliance...

The agent you choose in mild to moderate essential hypertension should offer (1) long-term effectiveness, (2) patient comfort, and (3) compliance.

Zaroxolyn offers all three.

Effectiveness: In several long-term studies[1,2,3] Zaroxolyn brought moderately elevated blood pressure (average 167/113 mm Hg) down to the range of normotension—and held it there for up to four years.

Comfort-in-use: One investigator noted, "Patient cooperation was surprisingly good for a study of such duration. The once-daily schedule with metolazone (Zaroxolyn) no doubt contributed to patient compliance."

Overall compliance with Zaroxolyn is good—very good. An analysis of controlled clinical studies involving 188 Zaroxolyn patients showed that only eight discontinued therapy because of side effects. That's a discontinuation rate of only 4.3%, and broader clinical experience appears to substantiate this low rate.[3]

Long-acting

Zaroxolyn®

(metolazone) Pennwalt

2½ mg, 5 mg and 10 mg tablets

once-daily antihypertensive diuretic

Recommended initial dosage in mild to moderate essential hypertension–2½ to 5 mg once daily

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents. Also, edema associated with heart failure and renal disease. **Contraindications:** Anuria, hepatic coma or precoma; allergy or hypersensitivity to Zaroxolyn. Or, as a routine in otherwise healthy pregnant women. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated Considerable potentiation may occur when given concurrently with furosemide When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing age requires that potential benefits be weighed against possible hazards to the fetus Zaroxolyn appears in the breast milk Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose Observe patients for signs of fluid or electrolyte imbalance. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Hyperglycemia and glycosuria may occur in latent diabetes Chloride deficit and hypochloremic alkalosis may occur Orthostatic hypotension may occur. Dilutional hyponatremia may occur in edematous patients in hot weather **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment may be necessary during the course of therapy **How Supplied:** Tablets, 2½, 5 and 10 mg

References:

1. Dornfeld L, Kane R: Metolazone in essential hypertension: The long-term clinical efficacy of a new diuretic. *Curr Ther Res* **18** 527-533, 1975
2. Cangiano JL: Effects of prolonged administration of metolazone in the treatment of essential hypertension. *Curr Ther Res* **20** 745-750, 1976
3. Data on file: Medical Department, Pennwalt Prescription Products

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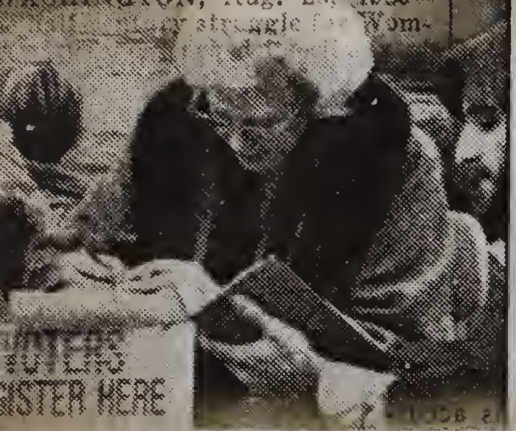
Vanted Movies of Ceremony, But Both Factions Are

WASHINGTON, Aug. 26, 1920—



Social Security Bill Is Signed; Gives Pensions to Aged, Job

Roosevelt Approves Message Intended to Benefit 30,00 Persons When States Adopt Cooperating Laws—He the Measure 'Cornerstone' of His Economic Progra

WASHINGTON, Aug. 14 The Social Security Bill, p a broad program of unemp insurance and old age p and counted upon to bene 20,000,000 persons, became day when it was signed b dent Roosevelt in the pre those chiefly responsible ting it through Congress.

Mr. Roosevelt cal "the cornerstone which is being me s compl

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sent to

TRUMAN CLOSES ED NATIONS CONFEREN TH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session the President accompanied the

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UL IGN the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the Secretary of the Army that

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy —and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA

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Category I Courses

Michigan Medicine *each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351*

Date: Oct. 11, Blood Coagulation for the Laboratory. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $50. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 7¼ hours of Category I Credit.

Date: October 12, Diseases of the Breast. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **Cost:** $50. **Contact:** Department of CME, St. John Hospital, (313) 881-8200, ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 12-14, Blood Coagulation for the Clinician. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $150 for physicians, $100 for Medical Technologists. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 17½ hours of Category I Credit.

Date: Oct. 13-14, Annual Conference, Organization of Michigan College Health Associations. Location: Albion College. **Sponsor:** American College Health Association. **For:** All interested physicians. **Cost:** $17 for members, $20 for non-members, $14 for students. **Contact:** Sandra Meeks, RN, 313/973-3478. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 13-15, Scientific Seminar and Alumni Meeting, Henry Ford Hospital Medical Association. Location: Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital Medical Alumni Association. **For:** HFH medical alumni. **Cost:** $50 for physicians, $25 for house officers. **Contact:** Jeanette Asher, Henry Ford Hospital, (313) 876-1034. **Approved for:** 16 hours of Category I credit.

Date: Oct. 14-15, Medical and Surgical Aspects of Gastrointestinal Disease in Infants and Children. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $90. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 11 hours of Category I Credit.

Date: Oct. 17-21, Family Practice Review I. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-Sponsor:** Michigan Academy of Family Physicians. **Cost:** $250 for physicians, $125 for physicians-in-training. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 37 hours of Category I Credit.

Date: Oct. 18-19, Institute on Medical Staff Bylaws. Location: Troy Hilton, Inn, Troy. **For:** All interested physicians. **Sponsor:** Michigan Hospital Association. **Co-Sponsor:** MSMS Committee on CME Programming. **Contact:** Michigan Hospital Association. **Approved for:** 10 hours of Category I Credit.

Date: Oct. 22, "Manifestations of Systemic Diseases in Sub-Specialties." Location: Inservice Classrooms, Holy Cross Hospital, 4777 E. Outer Drive, Detroit. **Sponsor:** Holy Cross Hospital Medical Staff Education Committee. **For:** All specialties. **Cost:** $25 for staff members; $35 for non-staff members. **Contact:** Kenneth K. Newton, MD, Director of Medical Education, (313) 369-9100, ext. 2355. **Approved for:** 6 hours of Category I Credit.

Date: Oct. 24-25, The Sibley W. Hoobler Symposium: Causes, Management and Control of Hypertension. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $100 for physicians, $55 for physicians-in-training. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 10¼ hours of Category I Credit.

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Date: Oct. 26, **Symposium on Birth Defects: Practical Diagnosis and Treatment. Location:** Mercy College, Detroit. **Sponsor:** March of Dimes, Metropolitan Detroit Chapter, and Wayne County Medical Society. **Co-Sponsor:** MSMS Committee on CME Programming. **For:** All interested physicians. **Contact:** Metropolitan Detroit Chapter, March of Dimes office. **Approved for:** 7 hours of Category I Credit.

Date: Oct. 27-28, **Seminar to Improve CME Instruction. Location:** MSMS headquarters. **Sponsor:** MSMS CME Programming Committee. **For:** CME instructors. **Cost:** $29. **Contact:** Herb Auer, MSMS Headquarters. **Approved for:** 9 hours of Category I Credit.

Date: Oct. 27-29, **Plastic Surgery in General Surgical Practice. Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education. **Cost:** $150 for physicians, $75 for physicians-in-training. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 15½ hours of Category I Credit.

Date: Oct. 28, **Clinical Symposium on Management of Coagulation Problems. Location:** Ingham Medical Center, Lansing. **Sponsor:** Ingham Medical Center, Department of Medicine. **Co-Sponsor:** Michigan State University College of Human Medicine. **For:** All specialties. **Cost:** $25. **Contact:** Maryanne Hollandsworth, Department of CME, IMC, 401 W. Greenlawn, Lansing, 48910, (517) 374-2107. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 1, **Symposium on Colon Rectal Cancer. Location:** Saint Mary's Hospital, Grand Rapids. **Sponsor:** Saint Mary's Hospital, Grand Rapids. **Co-Sponsor:** Ferguson-Droste-Ferguson Hospital. **For:** All specialties. **Contact:** Harold E. Bowman, MD, Director of Pathology, Saint Mary's Hospital, 200 Jefferson SE, Grand Rapids, 49503. **Approved for:** 6 hours of Category I Credit.

Date: Nov. 2, **"Current Therapy of Infectious Disease." Location:** Kalamazoo Hilton Inn. **Sponsor:** Michigan Academy of Family Physicians. **Co-sponsor:** SMAHEC. **For:** All interested physicians. **Cost:** None. **Contact:** Joe Alberding, Portage Medical Clinic, P.C., 225 E. Centre St., Portage 49081. **Approved for:** 7 hours of Category I credit.

Date: Nov. 3-4, **"Progress in Cardiology." Location:** Borgess Hospital, Kalamazoo. **Sponsor:** Borgess Cardiology Dept. **Co-sponsor:** SMAHEC. **For:** All interested physicians. **Cost:** $60. **Contact:** Robin K. Norbe, Cardiovascular Services, Borgess Hospital, 1521 Gull Road, Kalamazoo, 49001. **Approved for:** 10 hours of Category I credit.

Date: Nov. 4-5, **Twenty-Fifth Annual Symposium on Trauma. Location:** Harper Hospital, Second Floor Webber Wing, 3990 John R, Detroit. **Sponsor:** Michigan Committee on Trauma of the American College of Surgeons. **Co-Sponsor:** Wayne State University Department of Surgery. **For:** All interested physicians. **Contact:** Joseph L. Posch, MD, Chairman, 1408 Kales Building, Detroit, 48226, Ph: (313) 962-0727. **Approved for:** 9 hours of Category I Credit.

Date: Nov. 4-5, **Developmental Knowledge and Its Practical Application. Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $60. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 10¼ hours of Category I Credit.

Date: Nov. 5, **Laboratory Aids in Diagnosis. Location:** Henry Ford Hospital, Detroit. **Sponsor:** Henry Ford Hospital. **For:** All specialties. **Cost:** $50. **Contact:** Henry Ford Hospital, Medical Education Office, (313) 876-1464. **Approved for:** 7½ hours of Category I Credit.

Date: November 8-10, **MSMS Annual Scientific Session. Location:** Hyatt Regency Dearborn. **Sponsor:** MSMS Committee on CME Programming. **For:** All specialties. **Contact:** Herbert Auer, MSMS Department of CME Programming. (517) 337-1351.

Date: Nov. 9, **Cardiology for Family Physicians. Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-Sponsor:** Michigan Academy of Family Physicians. **Cost:** $60. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 7 hours of Category I Credit.

Date: Nov. 11-12, **Mammography. Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $60. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 9½ hours of Category I Credit.

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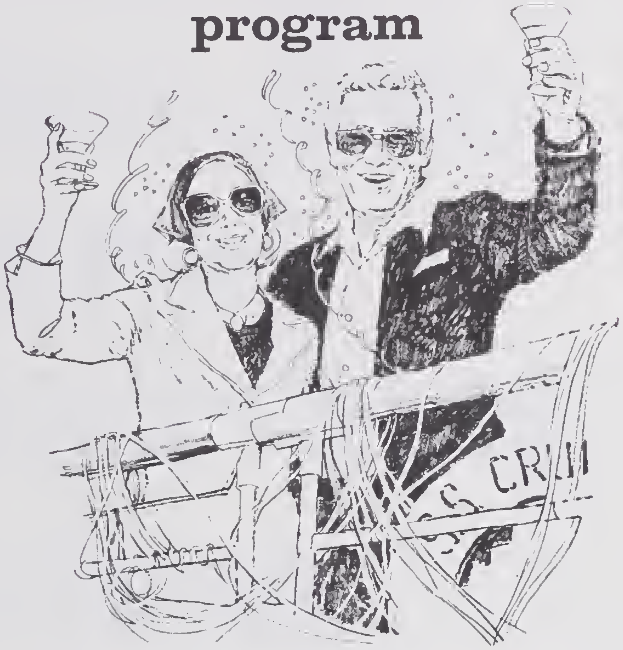

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Date: Nov. 16, Diseases of the Biliary Tract. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** All specialties. **Contact:** Department of CME, St. John Hospital, Detroit (313) 881-8200, ext. 321. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 16, "New Concepts in Neurology and Neurosurgery — A Course for Primary Physicians." Location: Hoffman House, Grand Rapids. **Sponsor:** Blodget Memorial Medical Center. **For:** Primary physicians. **Cost:** $35. **Contact:** Oliver Grin, MD, Blodgett Memorial Medical Center, 1890 Wealthy SE, Grand Rapids, 616/456-9507. **Approved for:** 7 hours of Category I Credit.

Date: Nov. 17, Psycho-Pharmacology. Location: Towsley Center for Continuing Medical Education, University of Michian Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $60. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 7 hours of Category I Credit.

Date: Nov. 26-30, Ophthalmology Review. Location: Dearborn Inn. **Sponsor:** WSU-Department of Ophthalmology. **For:** Ophthalmologists. **Cost:** $350. **Contact:** WSU Division of CME, Room 1209 Scott Hall, 540 East Canfield, Detroit 48201. **Approved for:** 40 hours of Category I Credit.

Date: Dec. 2, Care of the Burned Patient. Location: Towsley Center for Continuing Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-Sponsor:** University of Michigan Burn Center and National Institute for Burn Medicine. **Cost:** $15. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 6¾ hours of Category I Credit.

Date: Dec. 3, Seminar in Ophthalmology for the Primary Care Physician. Location: Detroit Institute of Ophthalmology, 15401 E. Jefferson, Grosse Pointe Park, 48230. **Co-Sponsors:** DIO and Bon Secours Hospital. **For:** All specialties. **Cost:** $50. **Contact:** Judi Dara, 313/824-4710. **Approved for:** 5 hours of Category I Credit.

Date: Dec. 10, "Needle Aspirations" Seminar. Location: University of Michigan, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** John F. Dunkel, MD, Department of Pathology, Michigan State University, East Lansing 48823 or James W. Landers, MD, Department of Pathology, St. John Hospital, Detroit. **Approved for:** 3 hours of Category I Credit.

Continuing Courses

Date: Continuing Quarterly Journal Club — Surgery. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Surgeons. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Monthly, Cleft Palate Clinic. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital****. **For:** Oral Surgeons, plastic surgeons, pediatricians. **Cost:** None. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 3 hours of Category I Credit.

Date: Monthly, Tissue Audit (Cancer). Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Surgeons, ob-gyns, pathology, radiology. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 2 hours per session Category I Credit.

Date: Monthly Lecture Series in Ophthalmology. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Ophthalmologists. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Monthly, Ob/Gyn Journal Club. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** All interested physicians. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Monthly Urology Journal Club. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Urologists. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital**** **Approved for:** 2 hours of Category I Credit.

Date: Begins September, Continuing Training in Family Therapy. Location: Suite 1212, North Park Plaza, 17117 W. Nine Mile Road, Southfield. **Sponsor:** Family Institute of Southeastern Michigan. **Co-sponsor:** Ackerman Institute. **For:** Psychotherapists. **Cost:** Varies according to time put in. **Contact:** Carolyn R. Tourkow, MSW, director, Family Institute of Southeastern Michigan. **Approved for:** Hours vary with time spent.

Date: Every Tuesday — Psychiatry — Special Problems Seminar. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Psychiatrists. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Every Tuesday morning, Gynecology/Obstetrics Combined Grand Rounds. Location: Jackson Auditorium, Hutzel Hospital. **Sponsor:** Wayne State University Department of Gynecology-Obstetrics. **For:** All interested physicians. **Cost:** No charge. **Contact:** Wayne State University, Division of CME**. **Approved for:** 4 hours each of Category I Credit.

Date: Each Wednesday, Detroit Medical Center Hand Conference. Location: Classroom 3, Second Floor, Webber Wing, Harper Hospital, Detroit. **Sponsor:** Wayne State University. **For:** Surgeons. **Cost:** No charge. **Contact:** Joseph L. Posch, MD, Fourteenth Floor, Kales Building, 76 W. Adams, Detroit 48226. **Approved for:** Hour-for-hour Category I credit.

Date: Second Thursday of each month, Inter-Hospital Pathology Slide Conference. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** Pathologists. **Cost:** No charge. **Contact:** Department of CME, St. John Hospital, 22101 Moross Road, Detroit, 48236, (313) 881-8200. **Approved for:** 3 hrs. each date Category I Credit.

Date: Saturdays — Intermediate Training in Family Therapy. Location: Northland Clinic, Southfield. **Sponsor:** The Family Institute of Southeastern Michigan. **Co-Sponsor:** Ackerman Family Institute of New York. **For:** Psychiatrists. **Cost:** $25 per session. **Contact:** Carolyn R. Tourkow, MA, MSW, Suite 1212, North Park Plaza, 17117 West Nine Mile Road, Southfield 48075. **Approved for:** 3½ hours of Category I Credit.

Date: Saturdays, Morbidity and Mortality Conference. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital Department of

(Continued on page 530)

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Surgery. **For:** Surgeons. **Cost:** None. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Aproved for:** 2 hours of Category I Credit per session.

Date: Every Saturday, Weekly Conference. Location: Gamble Building, Burns Clinic Little Traverse Hospital, Petoskey. **Sponsor:** Burns Clinic/Little Traverse Hospital. **For:** All interested physicians. **Cost:** None. **Contact:** Ernest W. Carpenter, MD, 560 West Mitchell, Petoskey, 49770.

Date: Every Saturday, Weekly Conference. Location: Gamble Building, Burns Clinic / Little Traverse Hospital, Petoskey. **Sponsor:** Burns Clinic. **For:** All interested physicians. **Cost:** None. **Contact:** A. D. Damschroder, MD, Chairman, Burns Clinic Medical Center, Petoskey 49770. **Approved for:** Hour-for-hour Category l Credit.

Date: Saturdays, Intensive Training in Family Therapy. Location: Southfield. **Sponsor:** The Family Institute of Southeastern Michigan. **Co-Sponsor:** Ackerman Family Institute of New York. **For:** Psychiatrists. **Contact:** Carolyn R. Tourkow, MA, MSW, Suite 1212, North Park Plaza, 17117 West Nine Mile Road, Southfield, 48075.

Date: Fall, 1977, Intermediate Training in Family Therapy — "Skills and Implements of Family Therapy." Location: Ann Arbor. **Sponsor:** The Family Institute of Southeastern Michigan. **Co-sponsor:** Ackerman Family Institute of New York. **For:** Psychiatrists. **Cost:** None. **Contact:** Carolyn R. Tourkow, MA, MSW, Suite 1212, North Park Plaza, 17117 West Nine Mile Road, Southfield, 48075. **Approved for:** 9 hours of Category I Credit.

Date: Fall, 1977, Intermediate Training in Family Therapy — Improving Communicaton Skills. Location: Southfield. **Sponsor:** The Family Institute of Southeastern Michigan. **Co-Sponsor:** Ackerman Family Institute of New York. **For:** Psychiatrists. **Cost:** $75. **Contact:** Carolyn R. Tourkow, MA, MSW, Suite 1212, North Park Plaza, 17117 West Nine Mile Road, Southfield, 48075. **Approved for:** 9 hours of Category I Credit.

Date: Wednesdays, Nov. 2, 9, 16, 23, Psychiatry and Self-Regulation: Biofeedback and the New Cognitive Therapies. Location: Zuckerman Auditorium, Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital of Detroit. **Co-Sponsor:** Michigan Psychiatric Society Rotating Lecture Series. **For:** Psychiatrists. **Cost:** $25. **Contact:** 313/493-6212. **Approved for:** 6 hours of Category 1 Credit.

Date: Thursdays, through December, Current Ophthalmology. Location: Kresge Eye Institute, 3994 John R., Detroit. **Sponsor:** Kresge Eye Institute of Wayne State University. **For:** Practicing ophthalmologists. **Cost:** None. **Contact:** Kresge Eye Institute of Wayne State University Detroit. **Approved for:** 2 hours of Category I Credit.

Date: Monthly, Saturdays - Sundays, Intensive Training in Family Therapy. Location: Southfield. **Sponsor:** The Family Institute of Southeastern Michigan. **Co-Sponsor:** Ackerman Family Institute of New York. **For:** Psychiatrists. **Cost:** $2,500 per year. **Contact:** Carolyn R. Tourkow, MA, MSW, Suite 1212, North Park Plaza, 17117 West Nine Mile Road, Southfield, 48075. **Approved for:** 120 hours of Category I Credit (must go to all sessions).

Date: Monthly, Saturdays, Intermediate Training in Family Therapy. Location: Southfield. **Sponsor:** The Family Institute of Southeastern Michigan. **Co-Sponsor:** Ackerman Family Institute of New York. **For:** Psychiatrists. **Cost:** $25. **Contact:** Carolyn R. Tourkow, MA, MSW, Suite 1212, North Park Plaza, 17117 West Nine Mile Road, Southfield, 48075. **Approved for:** 3 hours of Category I Credit.

Date: Jan. 4, 11, 18, 25; Feb. 1 & 8, 1978, Forensic Psychiatry for the Non-Forensic Psychiatrist. Location: Fisher Auditorium, Providence Hospital, Southfield. **Sponsor:** Providence Hospital. **Co-Sponsor:** The Michigan Psychiatric Society Rotating Lecture Series. **For:** Psychiatrists. **Cost:** $25. **Contact:** 313/493-6212. **Approved for:** 9 hours of Category l Credit.

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*Office of Intramural Education, University of Michigan Medical Center, Dep't. of PBM/HPE, Ann Arbor, 48109.

**WSU Division of CME, Room 1209, Scott Hall, 540 E. Canfield, Detroit, 48201 (313) 577-1453

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902

****Department of CME, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 493-5097.

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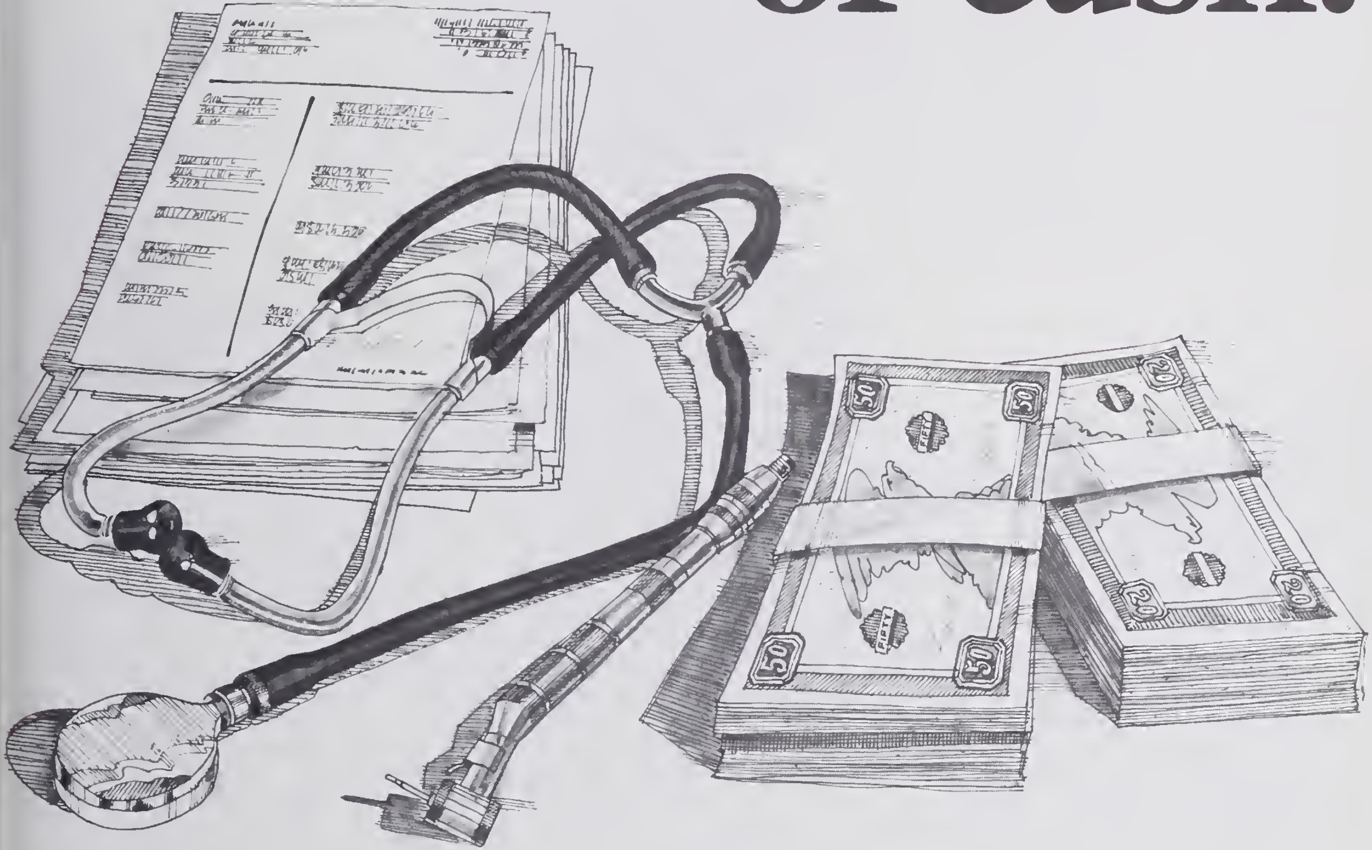

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Heartbeat

By Mert Scholten
MSMS Communications Department

Harper-Grace Hospitals thoracic surgeon **Augustin Arbulu, MD**, Detroit is president-elect of the Michigan Chapter, American College of Chest Physicians. Doctor Arbulu is professor of Surgery at WSU School of Medicine.

Regine Aronow, MD, Detroit, is a new appointee to a committee to advise the Michigan Department of Agriculture on administrating the Pesticide Control Act of 1976. B. Dale Ball, MDA director, noted that Doctor Aronow is "representing the medical profession and is experienced in the toxicology of pesticides."

The Michigan Academy of Family Physicians has honored MSMS staffer **Herbert A. Auer, East Lansing**, for his advice and assistance on public relations projects. Mr. Auer, MSMS deputy director, and manager, Division of Public Service, Communications and Physician Education, received one of the first three newly-established awards called the "Honor List." Each year the MAFP plans to honor one or more non-MDs in recognition of their service to family practice.

John Lehtinen, MD, Detroit, a graduate of the St. John Hospital Family Practice Residency program, July is staying on the job — as director of the program. He became the second director by succeeding E. J. Cetnar, MD.

William Middleton, MD, former student delegate to the MSMS House from the University of Michigan, is serving year-round as physician at the Mackinac Island Medical Center, financed by a two-year federal grant. Many newspapers around Michigan have carried stories and pictures of "Doctor Bill" with his bicycle, his major means of transporation around the island. Island fudge shops have added a new line to their sales pitch saying that if you "over-dose on fudge, the Doc will fix you up."

Raymond H. Murray, MD, East Lansing, professor of medicine and former chairman, Department of Community Health Sciences, Indiana University School of Medicine, is new professor and chairman of the Department of Medicine at MSU's College of Human Medicine. He succeeded **Scott N. Swisher, MD**, on August 1. Doctor Swisher, MSU's first chairman of medicine, resigned to devote more time to research in hematology and blood banking.

MSMS staffer **Helen A. Schulte, East Lansing**, manager, Office of Special Services, has been re-elected to the post of secretary-treasurer of the Organization Executives of Michigan.

H. Saul Sugar, MD, Southfield, will be honored at the Medical Physicians Division, State of Israel Bonds annual dinner-dance Nov. 9. Doctor Sugar, chairman, Department of Ophthalmology, Sinai Hospital of Detroit, will receive the State of Israel's newly established Maimonides Award for his interest in and support of Israel's growth and secure future.

Charles C. Vincent, MD, Detroit, associate professor of OB-Gyn, WSU School of Medicine, is new assistant dean for admissions at the school. A medical faculty member since 1963, Doctor Vincent earned his MD at WSU in 1958. He is past president of the Detroit Medical Society and was named Physician of the Year by that group in 1972.

Frederick B. Williamson, MD, Ypsilanti, was the subject of a newspaper feature story recently on the occasion of his retirement after 47 years of local medical practice. He is a 1928 graduate of the U-M Medical School.

Among Michigan authors . . . C. Cruz, MD and S. V. Shah, MD, Detroit had an article, "Dialysis Elbow" published in the July 18 issue of the Journal of the American Medical Association.

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*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

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WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children. Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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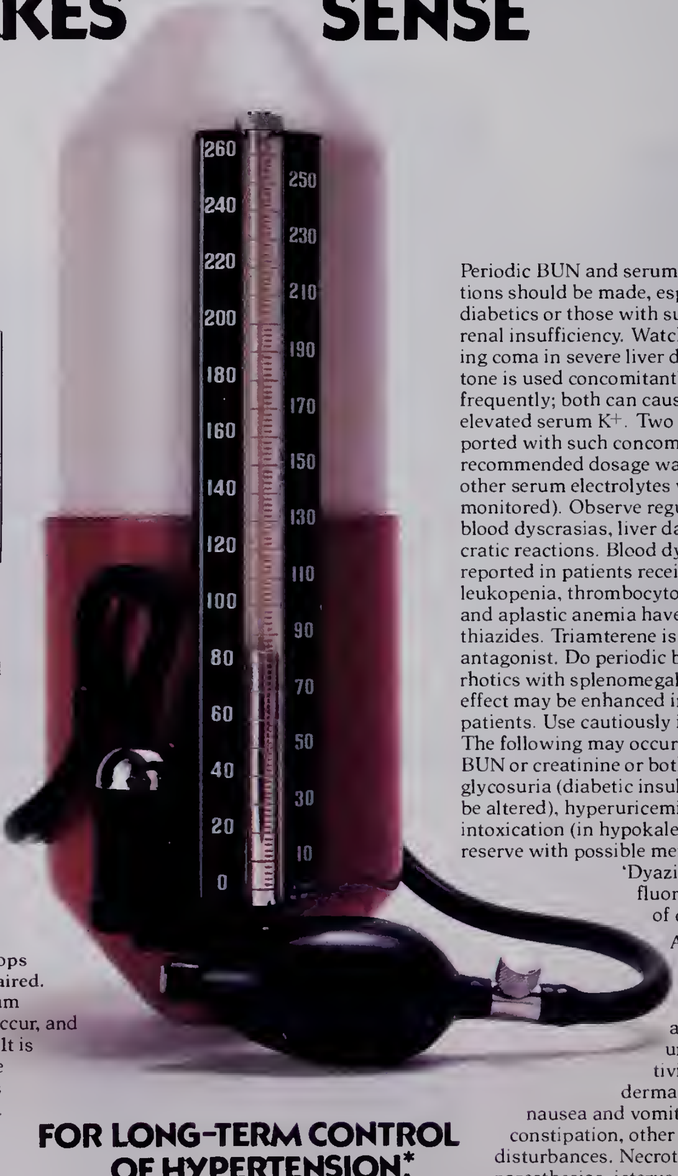

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* Warning
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.* SERUM K⁺ AND BUN SHOULD BE CHECKED PERIODICALLY. (SEE WARNINGS SECTION.)

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Medical Practice Board

By Sherry Wellman
MSMS Government Agency Liaison

The Medical Practice board is conducting random audits of physicians' records to verify continuing medical education credits reported for licensure renewal. Currently, the Board is advising physicians to maintain CME documentation for a period of two years.

At its meeting of Sept. 7, the Board approved proposed rules on standards of practice regarding amphetamines in the treatment of obesity, hyperactive children and narcolepsy. The Board has been in the process of developing the rules for two years with the cooperation of MSMS committees, specialty societies and many individual physicians. Before going into effect, the rules must undergo the administrative rules process, including public hearings. Copies of the proposed rules and dates of the public hearings are available from MSMS.

The Medical Practice Board has asked MSMS to remind physicians of the provision of Public Act 343 of 1925 which states: "The attending physician or in the absence of an attending physician, the coroner, shall fill out and sign the medical certificate of death or stillbirth within 24 hours after death."

Disciplinary Actions

The following disciplinary actions of the Medical Practice Board are presented here as a matter of public record. The language used is taken directly from the official notifications of the Medical Practice Board and is not editorialized.

Harold Richard Kostoff, MD, Port Huron, MI. After due consideration and deliberation, the Board issued the stipulation that the license to practice medicine be suspended from June 23, 1977 to September 23, 1977 and further that the licensee be placed on probation for two years commencing June 23, 1977 and ending June 23, 1979.

Albert Lucian Laura, MD, Livonia, MI. An order of summary suspension was issued March 2, 1977 by the Michigan Medical Practice Board. Pursuant to a formal hearing conducted May 19, 1977, the Board, at a regularly conducted meeting held June 15, 1977, suspended the Michigan certificate of Doctor Laura until January 1, 1978. The Board's decision was predicated on the findings of fact and conclusions of law in that Doctor Laura failed to employ acceptable and scientific methods in his prescribing procedures; sold drugs for other than legal and legitimate therapeutic purposes; departed from minimal standards of acceptable and prevailing medical practice, all committing violations of the Medical Practice Act 185, section 11 (b), 11 (c) and 11 (i).

Edward P. MacKenzie, MD, Detroit, MI. The Medical Practice Board based its decision of August 11 upon the findings that licensee violated section 11 (n)(r) of the Medical Practice Act, constituting the grounds for disciplinary action; specifically, the obtaining of, or attempting to obtain, money or anything of value by fraudulent misrepresentations in the course of the practice of medicine and unprofessional conduct. Thereby, the licensee was reprimanded.

Sue Ann Nagpal, MD, F/K/A Ganpat R. Nagpal, MD, Benton Harbor, MI. Through statutory authority, the Board based its August 11 action against licensee for alleged violation of section 11 (n)(r), that is, for obtaining money by fraudulent misrepresentations in the course of the practice of medicine and for unprofessional conduct. By an agreement, Doctor Nagpal will return her license to practice medicine in Michigan and her annual renewal license and will terminate her practice of medicine in the State of Michigan.

James Maxwell Cook, MD, Lansing, MI. On August 11, a limited license was set aside and a regular license to practice medicine was ordered. By previous agreement, the controlled substance registration and DEA registration remain permanently revocated.

Bruce Kendall Clark, MD, Temperance, MI. Predicated upon and adopting the findings of fact and conclusions of law, the Michigan Medical Practice Board revoked the license of Bruce Kendall Clark, MD. Substantiation was established that violations of section 10 (7), CME requirements; section 11 (e), inability to practice medicine according to standards of acceptable and prevailing medical practice by reason of illness . . . or as a result of a mental or physicial condition; section 11 (h), being guilty of immoral conduct; section 11 (r), unprofessional conduct, occurred. Further evidence established, non conformance to 1977 AACS, R 338.2377 Rule 77 (3) — CME requirement.

Nicholas J. Ellis, MD, Muskegon, MI. A letter of reprimand was issued by the Board and a stipulated agreement concluded after a compliance conference revealed violation of Public Act 185, section 11 (b), (c) and (i), that is, failure to use reasonable care and discrimination in the administration of drugs; selling, prescribing, giving away . . . drugs for other than legal and legitimate therapeutic purposes; a departure from or the failure to conform to minimal standards of acceptable and prevailing medical practice. Disciplinary action taken August 11.

Leonardo V. Lopez, MD, Birmingham, MI. License summary suspended August 15, 1977.

Primitivo P. Rivera, MD, East Detroit, MI. License summary suspended August 15, 1977.

Milton Palmer, MD, Detroit, MI. License summary suspended August 15, 1977.

Note: Members of the Michigan State Medical Society who have their medical license suspended by the Michigan Medical Practice Board are automatically dropped from membership in MSMS and the component medical society.

Meetings

(See also listing of Category I programs on page 526.)

Oct. 26 – Special Meeting of the House of Delegates, Troy Hilton, contact: Richard Campau, MSMS headquarters.

Nov. 2 – MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS Director.

Nov. 8-9-10 – MSMS Annual Scientific Meeting, Dearborn Hyatt Regency, Dearborn, contact: Herb Auer, MSMS headquarters.

Dec. 1 – "Travel Programs for Retirees," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

Dec. 8 – "Trust Fund," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

Dec. 10-13 – AMA Winter Scientific Meeting, Miami Beach.

Dec. 14 – MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS Director.

Jan. 12 – "Post Retirement Employment Opportunities for Physicians," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

Jan. 25 – MSMS Council, MSMS headquarters, contact: Warren F. Tryloff, MSMS Director.

Feb. 9 – "Investments for Retirement Income," presented by St. John Hospital, Dept of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

March 8 – MSMS Council, MSMS headquarters, contact: Warren F. Tryloff, MSMS director.

March 8-9 – Maternal Health Conference, Hyatt Regency Dearborn, contact: Herb Auer, MSMS headquarters.

April 13 – "The Physician's Family," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

May 5 and 7 – MSMS Council, Hyatt Regency, Dearborn, contact: Warren F. Tryloff, MSMS director.

June 17-22 – AMA Annual Meeting, St. Louis.

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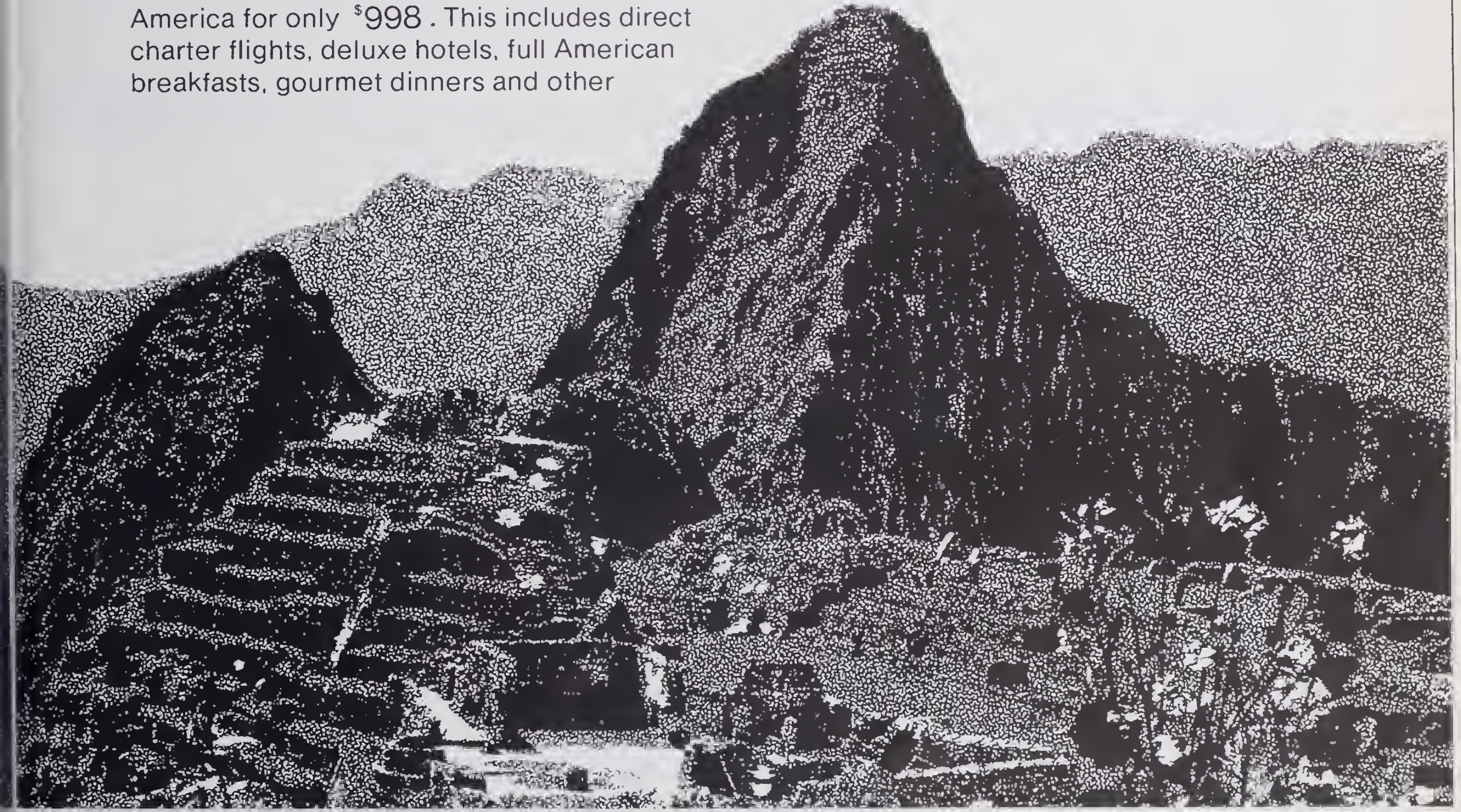

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In Memoriam

Hilda Case, MD, St. Clair Shores

Hilda Case, MD, St. Clair Shores, died Aug. 22 at the age of 71. Doctor Case was a retired clinical instructor in the Department of Physical and Rehabilitative Medicine at Wayne State University School of Medicine. She also was on the staff of the Rehabilitation Institute of Detroit.

Leslie T. Henderson, MD, Grosse Pointe Woods

Leslie T. Henderson, MD, 86 of Grosse Pointe Woods, died July 29. A graduate of Wayne State University School of Medicine, Doctor Henderson was former chief of staff at Deaconess Hospital. He also was former secretary of the Wayne County Medical Society, and was fleet surgeon for the Detroit Yacht Club as well as medical director of the Moslem Temple Shrine.

Fred J. Hodges, MD, Ann Arbor

Radiology pioneer Fred J. Hodges, MD, Ann Arbor, died July 29 at the age of 81. For 34 years Doctor Hodges served as chairman of the department of radiology at the University of Michigan Medical School. He was a professor emeritus at the time of his death. A graduate of the Washington University School of Medicine, St. Louis, Doctor Hodges pioneered the idea of routine chest x-rays and other radiology techniques. He helped organize the Michigan Memorial — Phoenix Project for the peaceful uses of atomic energy and later became chairman of the AEC Advisory Committee on Biology and Medicine. Doctor Hodges was recipient of the U-M Medical School Distinguished Alumni Award, and the Douglas Award of the Michigan Tuberculosis and Respiratory Disease Association. Doctor Hodges also served on the Advisory Committee on Lung Cancer Research, American Cancer Society; and the Advisory Committee on Medical Affairs for U.S. Veterans Administration, American Research Council.

John R. Hubert, MD, Pontiac

John R. Hubert, MD, a physician in Pontiac for 37 years, died July 31. He was 66. Doctor Hubert was a graduate of the Georgetown Medical School.

Robert S. Libke, MD, Gaylord

Robert S. Libke, MD, 60, medical director for Antrim, Charlevoix, Emmet and Otsego counties Health Department, died Aug. 21. Doctor Libke was from Gaylord. A graduate of Wayne State University School of Medicine, he had practiced in the Gaylord area for many years before accepting his position as health officer and medical director. He was a past president of the Michigan Health Officers Association.

J. Donald Mabley, MD, Grosse Pointe Farms

J. Donald Mabley, MD, Grosse Pointe Farms, died August 26 at the age of 79. Doctor Mabley practiced medicine in the Detroit area for nearly 50 years. A surgeon, he was a graduate of the University of Michigan Medical School, and was affiliated with Harper, St. John and Cottage hospitals.

Jacob J. Miller, MD, Livonia

Jacob J. Miller, MD, 53, Livonia, former chief of staff at Ann Arbor's Mercywood Neuro-psychiatric Hospital, died Aug. 13. He received his medical degree from the St. Louis University School of Medicine. He was a Fellow of the Menninger Foundation in Topeka as well as a Diplomate of the American Board of Psychiatry and Neurology. Doctor Miller was a clinical instructor in the Northville State Hospital residency program and on the staff of Livonia's St. Mary's Hospital.

John Olariu, MD, Ypsilanti

John Olariu, MD, Ypsilanti, died July 20 at the age of 63. Born in Romania, Doctor Olariu graduated with highest honors from Faculty of Medicine in University Cluj Romania and the University of Paris, France. He served in World War II, escaped from a concentration camp in Yugoslavia to Canada and the United States. He was a diplomate of the American Board of Psychiatry and Neurology. Doctor Olariu was a member of the APA, the Michigan Society of Gerontology and the Association of Hospital and Clinic Physicians. At the time of his death, he was director of gerontology and rehabilitation at the Ypsilanti State Hospital.

Charles B. Porter, MD, Fairplain

Charles B. Porter, MD, 69, of Fairplain, died August 2. Doctor Porter practiced for nearly 30 years. He served as an Army surgeon during World War II, and was former chief of staff of Mercy Hospital. He received his medical training at the University of Louisville.

Walter A. Schmutzler, MD, Kingsford

Walter A. Schmutzler, MD, Kingsford, died Aug. 9 at the age of 56. A graduate of the University of Cincinnati, Doctor Schmutzler was a past president of the Dickinson-Iron County Medical Society.

John C. Webster, MD, Marlette

John C. Webster, MD, 89, of Marlette, died July 15. Doctor Webster was a graduate of Wayne State University School of Medicine and was a physician for 55 years. He was a past president of the Sanilac County Medical Society and served in World War I.

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Please return this form with your check made out to the Michigan State Medical Society prior to November 1.

See note at bottom of page in order to make your own hotel reservation.

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Enter total amount due (number of courses × tuition) **$**
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(8:30 to Noon, including break)

(Write in blank 1 for first choice, and 2 for second choice)

* _____ Basic Cardiac Life Support
* _____ Combined Medical and Surgical Approach to the Patient with Angina (Part I)
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* _____ Myths, Perceptions and Realities: Physiological Aspects of Aging
* _____ Practical Otolaryngology
* _____ Prevention of Cardiovascular Disease: Diagnosis and Treatment of Hypertension and Hyperlipidemia
* _____ Recognition and Management of Sexual Problems in Clinical Practice
* _____ What's New and Different in the Treatment of Arthritis and Related Conditions

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TUESDAY AFTERNOON, NOV. 8

(1:30 to 5:00, including break)

(Write in blank 1 for first choice and 2 for second choice)

* _____ Advances in Nutrition for the Practicing Physician
_____ Appropriate Use of Physician Time in the Medical Audit Committee Function
* _____ Basic Cardiac Life Support
* _____ Combined Medical and Surgical Approach to the Patient with Angina (Part II)
* _____ Effective Utilization of Blood and Blood Products
* _____ Environmental Chemicals in Office Practice
_____ Flap Surgery: Reconstruction Versus Blood Supply (Part II)
_____ Radiation Therapy in Management of Breast and Colorectal Cancer
* _____ Treatment of the Elderly Patient: Practical Medical Guides
* _____ Why Wonder? — Just Call Nuclear Medicine

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WEDNESDAY MORNING, NOV. 9

(8:30 to Noon, including break)

(Write in blank 1 for first choice, and 2 for second choice)

* _____ Advances in the Understanding and Treatment of Acute and Chronic Renal Failure
* _____ Basic Cardiac Life Support
* _____ Health Problems of Children and Adolescents
* _____ Improving Physician-Patient Communications (or How to Avoid Malpractice Suits)
* _____ Management of Acute Poisonings and Overdose
* _____ Management of the Multiple-Problem Child And His Family, Focusing on Myelodysplasia
* _____ Newer Developments in the Diagnosis and Treatment of Epilepsy
_____ Para-Phenomena of Influenza
* _____ Practical Advances in Management of Pediatric Orthopedics
* _____ What's New and Different in Diagnosis and Treatment of Peptic Ulcer Disease — and Its Complications

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WEDNESDAY AFTERNOON, NOV. 9,

(1:30 to 5:00, including break)

(Write in blank 1 for first choice, and 2 for second choice)

* _____ Acute Bronchial Asthma — Pathophysiology and Treatment
* _____ Advanced Cardiac Life Support
_____ Colon and Rectal Surgery
* _____ Drug Allergy and Drug Related Reactions and Their Management
_____ Latest Advances for the Specialist in Otolaryngology
* _____ Management of the Multiple-Problem Child and his Family, Focusing on Obesity
* _____ Practical Considerations in the Use of Steroids and PUVA
* _____ Urinary Tract Infection: A Burning Issue
_____ What's New and Practical in the Management of Glaucoma and Cataract

Also U-M Media Library

THURSDAY MORNING NOV. 10

(8:30 to Noon including break)

(Write in blank 1 for first choice, and 2 for second choice)

* _____ Advanced Cardiac Life Support
* _____ Adverse Reactions to Drugs as Related to t Practicing Physician
* _____ Improving Physician-Patient Communicatio (or How to Avoid Malpractice Suits)
* _____ Newer Developments in the Diagnosis and Tre ment of Hospital-Acquired Infections
* _____ Perspicacious Evaluation of the Patient w Multiple Injuries
* _____ Problems of the Young Athlete
_____ Special Problems in Treatment and Rehabilitati of Burns and Injuries
* _____ Treatment of Symptomatic Coronary Artery Dise

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THURSDAY AFTERNOON, NOV. 10

(1:30 to 5:00, including break)

(Write in blank 1 for first choice, and 2 for second choice)

* _____ Carcinoma of the Lung
* _____ Exercise in the Diagnosis and Management Ischemic Heart Disease
* _____ Management Problems in Diabetes — 1977
* _____ Management of Inflammatory Bowel Disease
* _____ Manipulation and Mobilization in the Treatm of Musculo-Skeletal Myofascial Pain
* _____ Role of the Practicing Physician in the Treatm of Breast and Colon Cancer
* _____ Shock in Emergency Care: Prevention, Reco nition and Management of Organ Failure
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Michigan Medicine Contents

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about contemporary issues and actions of the Michigan State Medical Society, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

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550 MSMS position on national health policy; Richard J. McMurray, MD

554 Michigan physicians' suggestions for holding down health care costs; R. Jack Chase, MD; John H. Libcke, MD; James E. McGillicuddy, MD; Robert E. Paxton, MD; Josh S. Williams, MD

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The Publication Committee of the MSMS Council is the editorial board of *Michigan Medicine* and advises the Council and the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. In editorials, the views expressed are those of the writer and not necessarily official positions of the society.

In the next issue . . .

MSMS Council carrying out House of Delegates' directions re: new Blues' policies.

President's Page

Vernon V. Bass, MD
MSMS President

If cost control is our new bag, let's see what we can do

Most physicians realize that cost containment has not been their concern in the past. We were concerned only about delivering the best possible care.

But now the insurance companies, labor unions, businessmen and the government are saying that cost control is our problem. So, if cost control is our new bag, let's get into it and see what we can do about it.

Your state medical society is increasingly active in the battle to hold down costs. In May, the MSMS House of Delegates passed a key resolution for development of a broad-based educational program in cost containment to be presented to physicians, physicians-in-training and paramedics. Another key resolution called for deductible health insurance programs, which would result in patients shouldering their share of the responsibility and might cut down on utilization.

These resolutions were presented by the Michigan delegation to the AMA House at its annual meeting in June.

In addition, a new MSMS task force on health costs containment is being established. This task force will be chaired by F. W. VanDuyne, MD, Flint, former president, Michigan Medical Practice Board.

Isn't there more that local hospital staffs and individual physicians can do?

Hospital medical staffs should evaluate all their required procedures, to determine if they are cost-productive and whether benefits match costs. For example, resident and intern programs are extremely expensive for the local hospital, costing several dollars per hospital bed per day.

Review could be made of hospital staff rules requiring unnecessary cost increments, such as mandatory physician assistants in surgery; requiring history and physical exam, as well as an admitting note prior to surgery; routine chest X-rays, and multiple VDRLs.

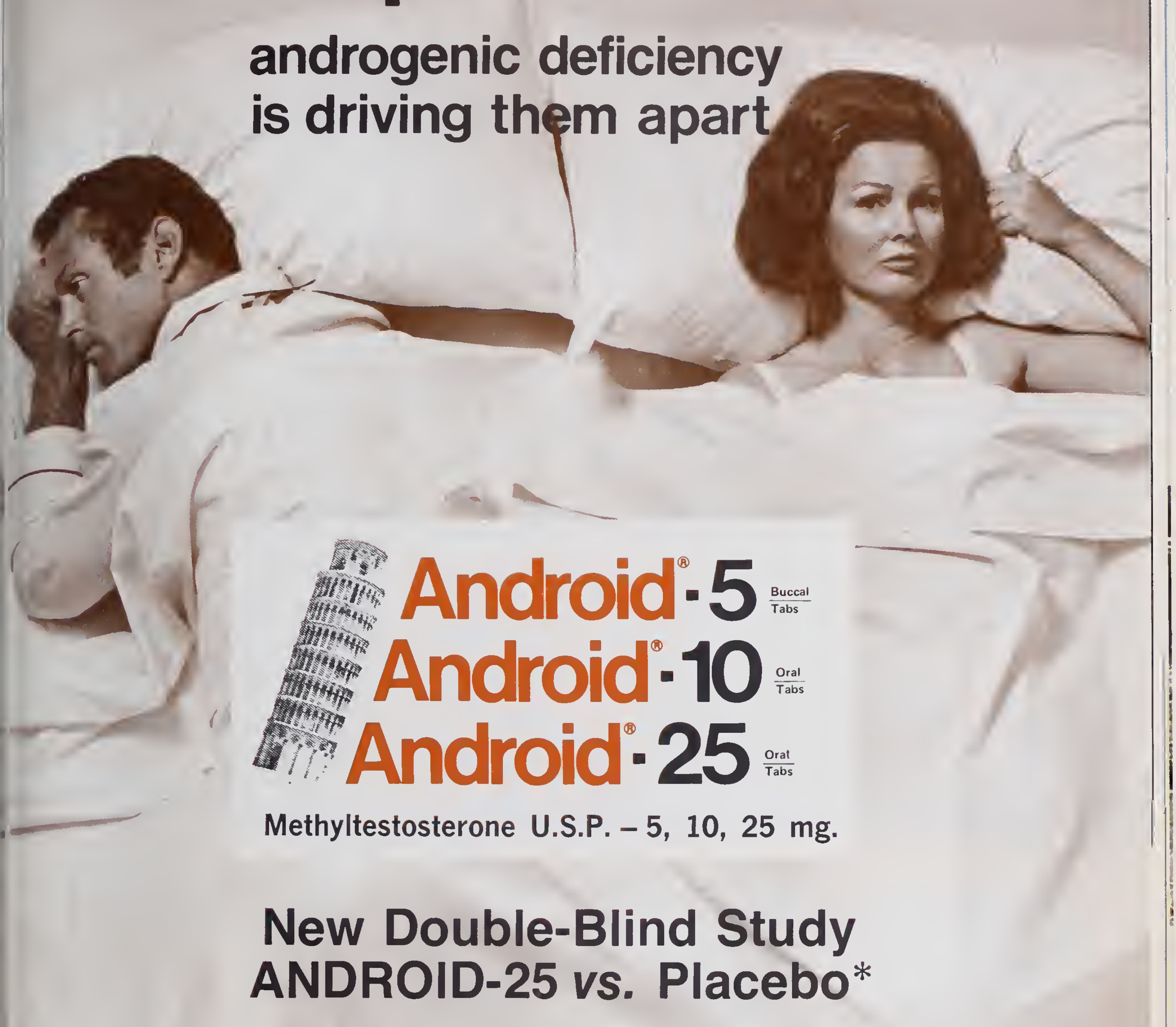
Physicians should evaluate all their medical activities with cost in mind. A lot of things we do, such as laboratory procedures that are frosting on the cake, maybe we don't really have to do. Maybe we don't need a specific procedure or can utilize a less costly one.

I call on my fellow MSMS members to take a positive stand, to believe we can do something to curb rising health care costs, and then to propose ways in which we can.

Let's share our ideas with our new task force. Let's initiate changes in our hospital and office procedures to economize without losing quality. I truly believe we can make a difference.

(For more MD's suggestions on holding down health care costs, please see page 554.)

When impotence due to androgenic deficiency is driving them apart



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New Double-Blind Study ANDROID-25 *vs.* Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; + + = 50% improvement; + + + = 75% improvement. Placebo effectiveness was + or + + in 12.7% of trials. Android-25 elicited a +, + + or + + + response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS**: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION**: Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg., Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg. Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.**: "The Menopausal Syndrome." *Problems of Libido in the Elderly*, pp. 95-101 Medcom Press, N.Y., 1974 **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only

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REFER TO PDR

Evaluation study underway of medical arbitration system

By William E. Madigan
Chief, MSMS Bureau of Negotiations

A 17-month study to evaluate the effects of the Michigan medical malpractice arbitration system gets underway this month.

The study is being conducted by a national firm under contract to the Michigan Insurance Bureau and the Michigan Arbitration Advisory Committee. Findings of the study, to be concluded April 1, 1979, are to be presented to the legislature.

The study will evaluate:

(1) Characteristics of claims filed under arbitration and litigation, including comparisons of those filed before and after the arbitration system.

(2) Extent or degree of participation in arbitration through early or later agreement and final selection at time of alleged malpractice.

(3) Attitudes toward and understanding of arbitration by patients, providers, insurers and others; satisfaction with use of the process at various stages.

(4) Impact of arbitration on changes in malpractice insurance patterns, and medical care patterns, including risk management.

(5) Costs or expense of accepting and maintaining arbitration on the part of providers and insurers.

The study is part of a comprehensive research program of the Michigan Department of Commerce to assess the impact and success of the arbitration system. The goal is to develop state policies and programs to achieve state medical malpractice insurance objectives.

"Policies and laws that enhance the insurability of health care providers are in the best interest of the state," says the Department of Commerce study proposal.

While the study gets underway, the Michigan Arbitration Advisory Committee is conducting a campaign to educate physicians, hospital personnel and the public about the arbitration system.

Posters have been placed in 235 hospitals; radio messages and TV commercials are being developed. In addition, workshops have been conducted for employes of hospitals around the state.

The Education and Training Subcommittee of the advisory committee also plans to contact physicians to clarify aspects of the system.

The Arbitration Advisory Committee has 18 members; half of them represent the public, the other half represent health care providers, insurance industry and the legal profession. Representing MSMS on the committee is Rhoda Powsner, MD, Ann Arbor.

Following are the latest figures on the use of the Michigan medical arbitration system:

17 cases filed to date
8 filed against hospital only
7 filed against both hospital and doctor
2 filed against doctor only

10 cases filed over incidents in out-state area
7 cases filed over incidents in Detroit-Macomb-Oakland area

12 cases filed by attorneys for the claimants
5 cases filed by claimants themselves

1 claim filed alleged death due to medical malpractice
8 claims alleged permanent damage

Damages claimed range from $750,000 to cost of the operation.

Arbitrators needed

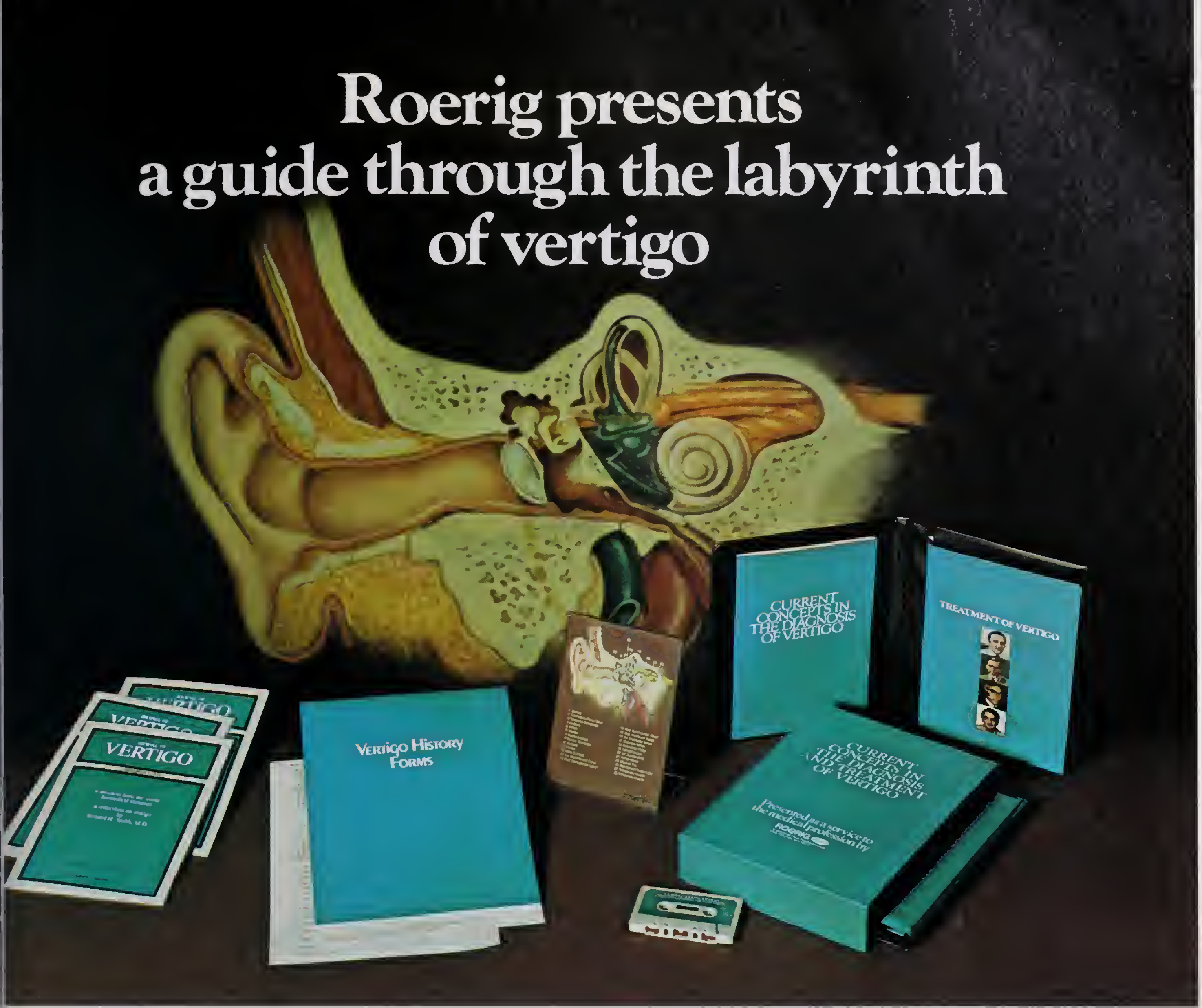
Dear Fellow MSMS members,

Your help is needed to assure that Michigan's medical arbitration system can run smoothly. MSMS supports the system and has pledged to help it succeed.

Physician response has been good and large numbers of MDs have offered to serve on the arbitration panels. But more physicians from certain specialties — pathology, therapeutic radiology, neurology, thoracic surgery, plastic surgery, allergy, anesthesiology, colon and rectal surgery, and general practice still are needed. The arbitration system is designed so that specialists hear cases from their own field, to ensure informed decisions.

We urge those specialists and their societies to come forward with individuals who can serve. Please contact Michael Arford, American Arbitration Association, 1234 City National Bank Building, Detroit, MI 48226.

Vernon V. Bass, MD
MSMS President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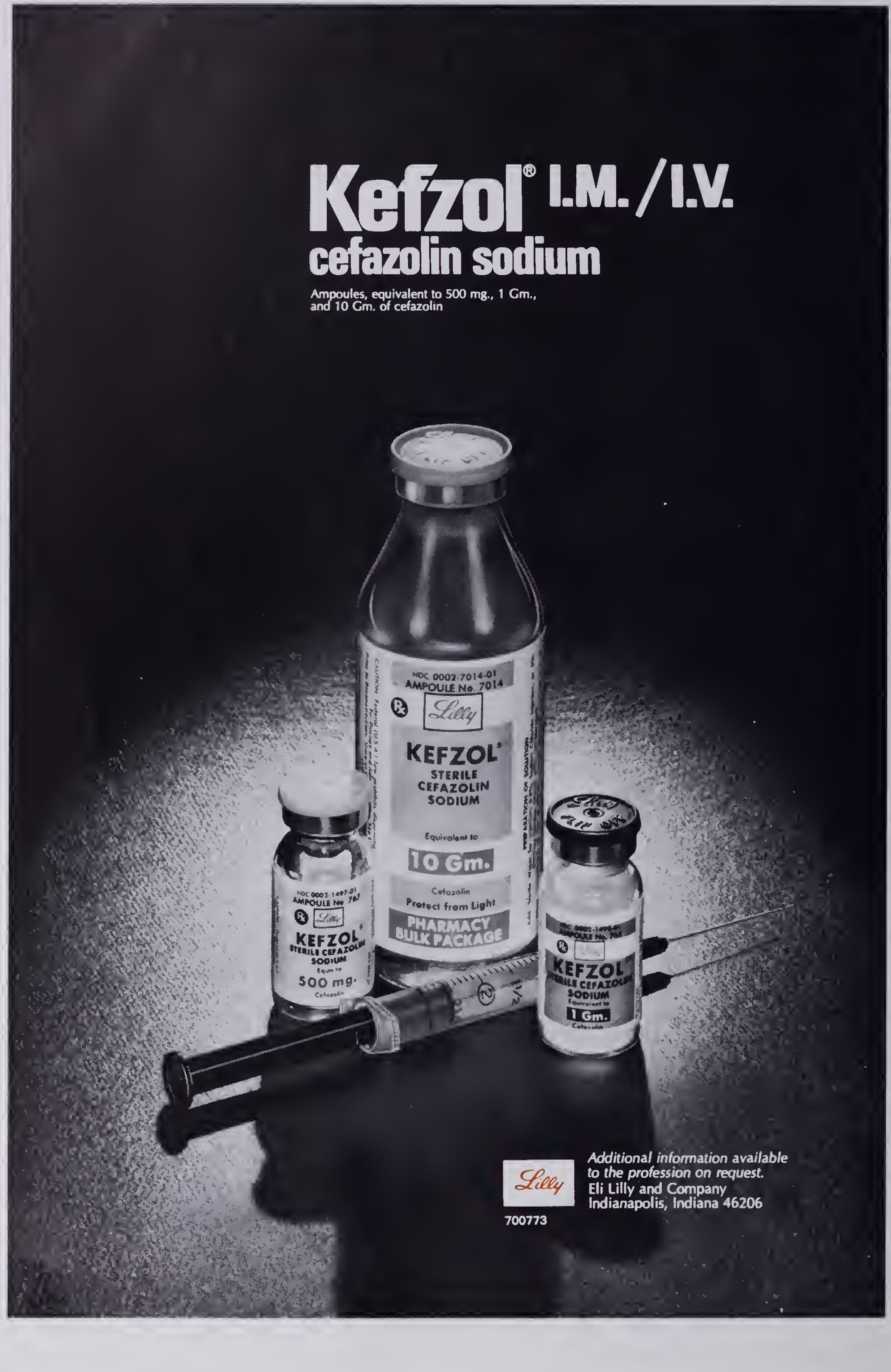
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When John Budd, MD, Ohio, center, current AMA president, spoke recently to the Wayne County Medical Society general membership, he also met with MSMS President Vernon V. Bass, MD, Saginaw, left, and AMA Trustee John J. Coury, MD, Port Huron, past MSMS president.

MSMS president-elect Louis E. Heideman, MD, Birmingham, left, and Council chairman Ernest P. Griffin, Jr., MD, Flint, center, met recently with William Ballenger, head of the Michigan Department of Licensing and Regulation. Mr. Ballenger and his staff met with MSMS leaders to discuss common concerns.

MSMS supports pluralistic insurance system, but insurance must be available to all

The accompanying MSMS Statement of Principles on National Health Policy was prepared in the past several months by a special MSMS task force and was submitted to the AMA on Oct. 10. It was prepared to help the AMA in its efforts to influence national health policy. Following are the task force's findings.

By Richard McMurray, MD
Task Force Chairman

The Task Force based its recommendations on extensive readings, self-analysis, reviews of proposed National Health Insurance programs, and an attitudinal survey of members of the Michigan State Medical Society House of Delegates conducted May 13, 1977.

Because there was no way to develop, in a short time, extensive or definitive findings, the Task Force addressed itself to the needs of Michigan which it believes to be reflective of the entire nation. The Task Force relied particularly on the attitudes of MSMS members who responded to the survey or who took time to write the Task Force on personal attitudes.

Findings and Conclusions

The Carter Administration's promise to institute National Health Insurance legislation, and its subsequent appointment of a task force to develop policies for legislation, causes national health insurance to be more topical for discussion than ever before. The great debate is upon us. Legislative activity can be anticipated in 1978.

The AMA has supported a form of national health insurance legislation

MSMS statement of principles on national health policy

I. Every American should be protected by some form of health insurance.

II. The Federal government in conjunction with organized medicine, should establish minimum guidelines and service benefits for all health insurance policies, whether government or private, to assure patients adequate protection.

III. The National Health Policy should provide for financial incentives in the form of tax credits or deductibles to encourage employer-employee health insurance coverage, and for individuals not otherwise covered to obtain their own health insurance protection.

IV. State and Federal governments should provide health insurance protection for those unable to afford their own on a shared cost basis, and that insurance should be provided through the private insurance market.

V. The Federal government should maintain the Medicare health insurance program for the elderly.

VI. To assure *continuing quality health and medical care* in the United States, any National Health Policy should include:

1. Patient freedom of choice to select their own physicians.
2. Physician freedom of choice in acceptance of patients.
3. A pluralistic system of health and medical care delivery which includes the traditional fee-for-service system, prepaid contract medical services, HMOs, and any innovations as they may arise.
4. A program for all patients to gain access to appropriate professional services and facilities through the use of sophisticated communications systems, transportation units and other modern technologies.

VII. To assure *maximum benefits for patients* with administrative efficiency and economic restraint, any National Health Policy should include, in order of priority:

1. Catastrophic coverage as its first priority, to include both inpatient and outpatient services.
2. Comprehensive inpatient hospital services.
3. Preventive services, emphasizing health education as well as the usual kinds of prevention (i.e., immunizations, etc.).
4. Assurances of access to physicians and hospitals.

MSMS national health policy task force chairman Richard J. McMurray, MD, standing, confers with Bruce Ambrose, MSMS deputy director and head of the MSMS Division of Government Relations.

VIII. To assure *adequate financing and economy* in the delivery of health and medical care, any National Health Policy should include:

1. **Fiscally sound co-pay or deductible features administered as simply as possible.**
2. **Patient responsibilities and restraints.**
3. **Physician control of monitoring of utilization and standards of practice.**
4. **A system of rate reviews for facilities and professionals.**

IX. To assure the most *equitable and efficient administration,* any National Health Policy should include:

1. **Private insurance for all who can purchase it (either through employee status or individually) that meets minimum guidelines and standards prescribed by the Federal government.**
2. **Local planning for services and facilities.**
3. **Administration at the State level (i.e., Medicaid) subject to the guidelines and standards established by the Federal government.**
4. **Flexibility in the eligibility for government-purchased insurance protection that will allow patients to move in and out of the program as their ability to pay changes.**

X. MSMS recognizes the AMA's "Comprehensive Health Care Insurance Act" as a statement of principles by America's doctors acting collectively in the debate on National Health Policy, and MSMS will work jointly with the AMA to achieve its goals for a National Health Policy.

XI. MSMS applauds the Carter Administration's announced intention to phase-in any National Health program on a priority of need basis.

FINDINGS / *Continued*

in each Congress since 1971. Its current proposal, the "Comprehensive Health Care Insurance Act," is a development from AMA's original "Medicredit" proposal. AMA's basic tenets have been for minimum federal administrative involvement, state jurisdiction under federal guidelines, shared funding by the public sector and the private sector, pluralism in the delivery of care, comprehensive protection for the total population, and bilateral freedom of choice for both physician and patient.

The AMA proposal comes into conflict with several other NHI proposals over costs, federal autonomy, sources of revenue, government vs. private insurance, and most importantly, whether NHI should be purely an insurance protection plan or a comprehensive plan for national health care.

*Insurance coverage in Michigan**

1. Approximately 60 per cent (5.3 million) of the population is covered by Blue Cross/Blue Shield of Michigan. Of this number 4,575,000 were covered by group plans and 725,000 were covered by individual plans. (Because of the unusually broad benefits package in Michigan of the UAW benefits program, and the disproportionately high number of auto workers in the State, Michigan BC/BS figures probably are high in comparison to other states.)

2. In February of 1977 there were 866,297 Medicaid-eligibles.

3. At the same time there were 1,837,000 Medicare-eligibles. There is, of course, a significant overlap between Medicare and Medicaid-eligible citizens, including mostly the elderly poor.

4. Best estimates indicate that approximately 27 per cent (2.4 million) of the Michigan population was cov-

NHI / *Continued*

ered by private commercial health insurers (Aetna, Hartford, Hancock, etc.)

5. Approximately three per cent, or some 270,000 persons in Michigan, had no coverage at all, either by choice or because they do not qualify in any employer-employee plan or Medicaid. Some of them fall upon county-level direct relief; others simply have no resources to obtain health and medical care.

The average per-patient Medicaid cost in Michigan in 1976 was $719.97.*

Michigan's number of Medicaid-eligibles is apparently out of proportion to percentages in other states, perhaps as much as double. That may be attributable to a number of factors, but certainly two factors come into play: Michigan's relatively broad eligibility constraints, and an economic downturn in the State in 1976.

National health insurance will impose on 90 per cent of the population a new financial burden for the benefit of 10 per cent of the population, which, unless accompanied by severe economic restraints, could lead (as in Great Britain) to national economic bankruptcy.

The Task Force attempted, but was unable, to determine with documented data how many persons in the State believe they are adequately protected, but are not. Protection against inadequate insurance appears to be a necessity, however.

The unit cost of service seems to rise with the increase of federal government in program administration.

A very real problem which is often overlooked lies with the small group of citizens either with *no* health insurance or *inadequate* protection.

Cost rises disproportionately with the extent of ancillary services provided in a benefit program that may not be necessary to the good health of the patient.

An insurance program can be developed to cover the nation's total population in the private sector, with government insurance only for those with no, or inadequate, protection. In the opinion of the Task Force, this would be most beneficial to the population and least expensive.

There is a direct relationship between patient cost-sharing and efficiency of utilization.

The major contribution by both federal government and organized medicine should be to establish guidelines and minimum standards for the private health insurance industry to follow.

"The task force feels strongly that medical care in the U.S. is excellent," said the special MSMS national health policy committee in its report to the MSMS Council. " . . . we should continue to build on the present pluralistic fee for service program with insurance being provided by the private sector. However . . . a certain segment of the population to date has no third party coverage . . . it becomes mandatory that these people have made available to them third party coverage. It is apparent we will have some type of subsidized medical service . . . the choice should be made by the profession and not by the government."

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*Data provided by Michigan Department of Social Services.

MSMS supports U-M study of preoperative consultation

The MSMS Council has voted approval and continued support of the statewide preoperative consultation study in elective surgery projected by the University of Michigan Health Services Research Center.

The Council took the affirmative action after assurances were made the proposal meets stipulations adopted by the 1976 MSMS House of Delegates and reaffirmed in 1977.

Preparations for the four-year U-M study began Oct. 1, with consultations to begin June 1 and follow-up expected to begin April 1, 1980. The project is to study the decision-making processes by which surgeons, consultants and patients decide whether or not to proceed with elective surgery.

Eligible patients will be those across the state whose health care is paid for by Medicare, Medicaid, Blue Cross/Blue Shield (except auto workers within the tri-county area), and commercial health insurers.

A restricted list of procedures will be covered. Beverly C. Payne, MD, Ann Arbor, is research center director.

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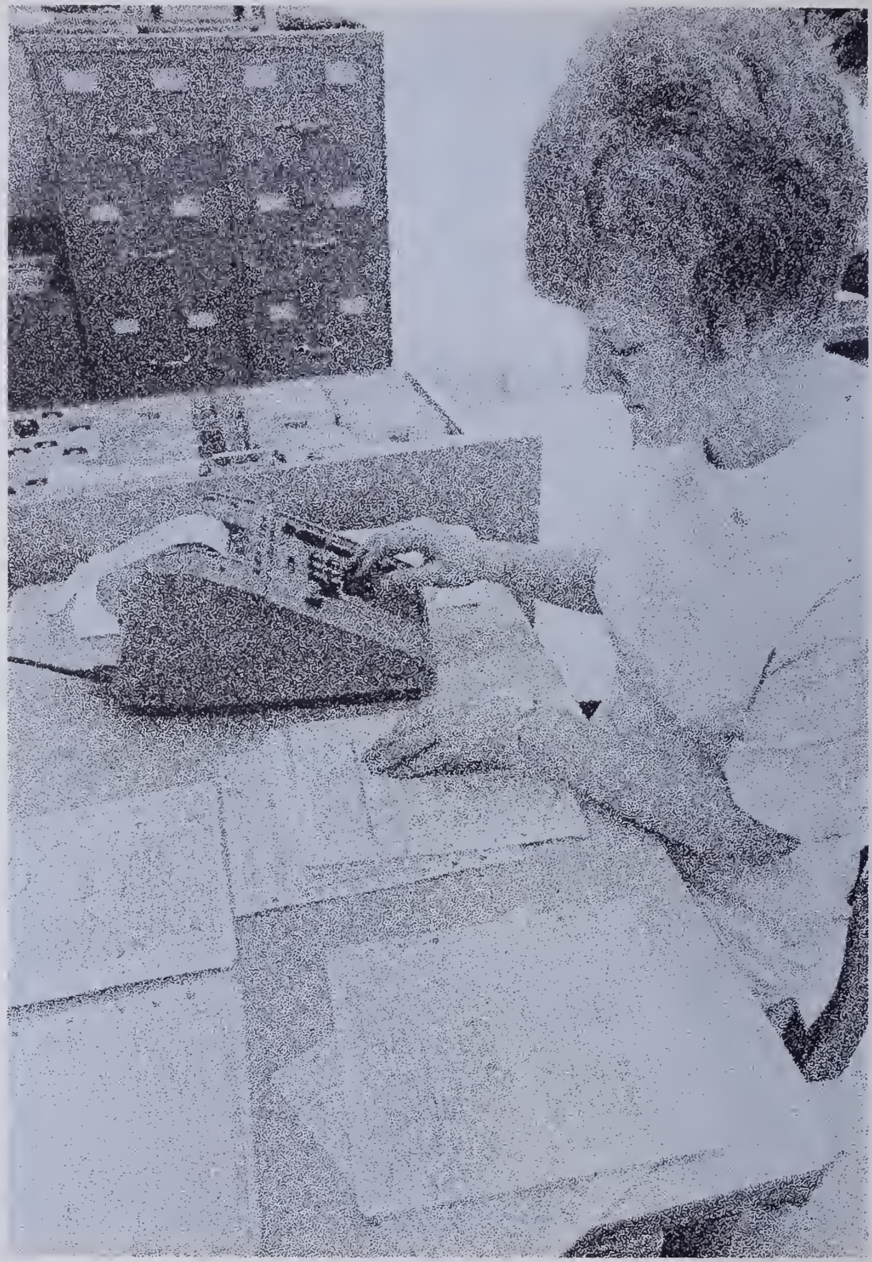

Can Michigan physicians hold down health costs?

Let us remember patients' financial best interests, too

Michigan Medicine wrote a number of MSMS members recently asking them to share their thoughts on cost containment, and to make specific suggestions for holding down costs. Their ideas follow:

By R. Jack Chase, MD
Grand Rapids

Because most medical care is under our direction, we physicians must recognize that we exert a profound control on the cost of medical care. Always we must have our patient's best interests at heart, but let us also remember their financial best interests too. I am really fearful that if we do not do this it will be done for us, and medical care will suffer.

Medical cost awareness should be taught in medical schools and continue through our medical life. The medical student should be aware not only of the value of a test or procedure, but also of the indications or

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Doctor Chase is an internist.

necessity of that procedure, and of its cost.

In post-graduate training years, we can counsel our house staff physicians to objectively decide what really needs to be done and what is extraneous. Such orders as daily electrolytes, blood counts, blood sugars, and similar tests, day after day cost dollar$. Simply checking the chart before ordering tests often saves us reduplication.

"Defensive medicine" in our offices and the emergency room is not necessarily the best medicine. A great battery of tests may tell us nothing, and a few concise questions or an astute exam may confirm a diagnosis. Does a patient with costochondritis need cardiac enzymes, a chest X-ray, and an EKG? Usually not. Does a patient with radicular Herpes Zoster pain at T-11-12 segments need a renal stone work up, when typical skin rash is present? I think not, but I have seen both examples of this.

And how do we answer these questions: Is this hospitalization really necessary or is it being done because insurance covers it? Could this be done as an outpatient procedure? Is this surgery really indicated? Do I need an expensive antibiotic when an old inexpensive standby will do? Am I having this consultation for the patient's own well being, or my own? If we cannot give logical answers to these questions, perhaps we should reconsider.

Certainly all of us can think of ways in our office and in the hospitals to increase efficiency. The larger an office or hospital becomes, the more impersonal and less efficient it seems to become also. We cannot assume a cost plus attitude towards medicine at any time in our office or in the hospital.

Patient education is a continuing process and serious abuses of medical care arise because of third party carriers and first dollar coverage. We can discourage unneeded visits to our office and certainly the expensive and often unnecessary emergency room visits. Medicaid patients who take unnecessary ambulance rides to the emergency room waste millions in Michigan annually. Non-emergent weekend visits to the emergency room could often be avoided with a prior phone call to the personal physician. We cannot allow our ethics to be compromised personally, professionally, or financially. Those who abuse third party coverage should be made aware of that abuse and the carrier should also be made aware.

Cost containment need not mean less adequate medical care. It does, for the physician, mean more attention to detail, less ordering of repetitive or reduplicative tests and procedures, and assurance to the patient and third party carriers that what we are doing is relevant, timely, indicated, and in their best interest.

MSMS members are urged to share their ideas with the members of the new MSMS Task Force on Health Care Cost Containment. Members may write or telephone the committee at MSMS headquarters, 120 W. Saginaw St., East Lansing, 48823, (517) 337-1351.

Committee chairman is: Frederick W. VanDuyne, MD, Flint.

Doctor Chase

Doctor Libcke

There are modest savings MDs can effect

***By John H. Libcke, MD
Pontiac***

In the course of polling clinicians in our institution on the subject of cost containment by physicians and hospital staffs, it became apparent that implementation of all their suggestions would result in very modest savings compared to the monumental inflationary pressures exerted by the malpractice-defensive medicine syndrome, the technological explosion, the single business tax, and rising (or risen?) patient expectations, among others. Nevertheless,

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Doctor Libcke is director of laboratories at Pontiac General Hospital.

a few suggestions seem to merit consideration.

Although the medical profession pioneered in the early ambulation and discharge of surgical and obstetrical patients long before the days of utilization review, there are patients today who are kept in the hospital for reasons of personal convenience. At today's rates this is no longer defensible and they should be discharged to alternative care as soon as possible. This is not to recommend that surgical patients be discharged so early as to complicate their convalescence; obviously, it is a matter of judgement.

Many hospitals have routine admission tests prescribed. Does a healthy 16 year old having a minor elective procedure really need an 18 channel chemistry panel and a serology? Selective ordering of preoperative tests might be more appropriate.

Where blood transfusion is contemplated, the standard approach is to type and crossmatch so many units before surgery, yet many studies have shown that a large number of the procedures for which blood is routinely crossmatched use little or none. In these procedures the order to type and hold or type and screen is more appropriate and not only saves money, but more importantly conserves blood.

Moving into the operating room we find the surgeon who sends a specimen out for frozen section and then appears in street clothes before the slide is stained! Whether the motive was personal curiosity or a desire to "tell the family something," when the frozen section is used for reasons other than to direct therapy it is an abuse of the pathologist's time and the patient's pocketbook.

On the postop ward we find the eager resident ordering daily electrolytes on an uncomplicated appendectomy. Won't his attending physician be pleased? I hope not. Closer supervision of house staff ordering practices, including duplications, is not only good economics, but good medical education. Along the same line, specified *stop orders* will prevent daily serum porcelains for two weeks after the physician has forgotten why he ordered them in the first place. We employ a 72-hour stop order on all tests except prothrombin times and APTT's.

Other approaches would include a more efficient use of the problem-oriented record, broader public education programs such as Tel-Med, and a more comprehensive health program for our most rapidly growing population group — the elderly, whether in nursing homes or out.

And yet the shadow of external forces clouds over these small areas of physician initiative.

Physicians must promote cost controls

By James E. McGillicuddy, MD Lansing

The best and most practical way for doctors, hospitals and medical professionals to effect cost containment is by decreased utilization of services. First, we must accept the fact that we are a limited resource dealing with limited resources and not a particularly popular one at that. Second, we must all make a concerted effort to retrain our patients and society in general to accept shorter periods in the hospital and fewer testing modalities.

One important factor is that we, as medical professionals, become very visible and vocal proponents of cost containment possibly even in excess of our actual attempts at cost containment. People like to feel that something is being done even if this is not the case. Let us then turn to the magazines, newspapers, and let us make a beginning.

Doctor McGillicuddy is a general surgeon.

Most important is to avoid over-utilization

By Robert E. Paxton, MD Fremont

Cost containment is a multifaceted, controversial subject which physicians no longer can ignore. There are certain cold facts:

1. Like it or not, the physician has considerable responsibility towards cost containment. We challenge you to add the total

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Doctor Paxton is a family physician.

Doctor Paxton

Doctor Williams

cost of health care that you personally might generate in a single day. One physician in a small town did this and it is documented that on a given day he triggered $13,400.00 in hospital costs, consultations, drugs and diagnostic procedures.*

2. Physicians have a responsibility toward the individual or third party providers that pay these costs. Failure to assume that responsibility will only lead to cost containment policies dictated by parties such as government not aligned with nor knowledgeable of the medical profession.
3. Physicians no longer can use high sounding rhetoric such as "What's best for the patient" or "In my judgment" to cloak feeble reasons for over utilization such as convenience for patient or doctor.

To preface my remarks I would emphatically state that we must continue to provide the best medical care for our patients. This is paramount. Nevertheless, there are numerous areas where we can provide cost containment without jeopardizing excellent medical care. Of the many ideas suggested, the most important concept is to avoid over utilization.

Physicians and organized medicine must take a long hard look at indications for surgery and hospitalization — we must pursue the concept of outpatient surgery and diagnostic procedures. We must be ready to seek and seriously evaluate a second opinion on a not so clear cut choice of treatment.

Over utilization of unnecessary consultations must be avoided. Family physicians should not refer just to get a hypochondriac off his back nor because he won't take the time to treat within his ability. Many unnecessary referrals by specialists also occur daily and should be avoided.

As I see it, the most practical area where we as physicians can be involved in cost containment is in the over utilization of diagnostic lab and x-ray procedures. Today the art of physical diagnosis is over shadowed by the practice of defensive medicine. Take a critical look for example, at the volume of procedures ordered by Emergency Room physicians and residents to cover themselves. We should be able to rely upon our ability as clinical diagnosticians without ordering unnecessary multiple screening tests and x-rays and furthermore be ready to defend it in malpractice. But physicians are known for their "intestinal fortitude" and should be willing to display it. I believe that defensive medicine must be terminated and its practice discouraged in medical schools and residency programs. This will go a long way toward cost containment.

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*See "Face-Off: Cost Containment vs Chaos" *Patient Care* — January 1, 1977, Page 10.

Early discharge from the hospital key to savings

By J. S. Williams, MD Detroit

My submittal for health care cost containment is EDAM. This is my own acronym for Early Discharge to Ambulatory Management. Since I know that it worked when some of my patients had to meet their hospitalization costs from both insurance and personal cash, I have no doubt that in select diseases, with selected patients who have adequate home and family support, it is feasible today.

For the sake of simplicity, assume that a patient is hospitalized for suspected acute peptic ulcer. Assume the days allowed by the utilization review committee for uncomplicated peptic ulcer are 14. If uncomplicated duodenal ulcer is confirmed by the third or fourth hospital day and there is a favorable response to the physician's management, the doctor could elect to discharge the patient to his home to be followed by ambulatory treatment at the office. The decision would be made after appropriate conference with patient and family.

The patient would then be allowed to make three visits per week to the physician's office at the insurer's expense for a maximum of three weeks; all medicine, x-rays, and laboratory tests relevant to the in-patient diagnosis would continue as an insurance benefit.

The key elements are: 1. There is a dis-incentive for the physician or the patient to extend hospitalization to assure continuation of benefits; 2. The whopping $200± per day hospital charge is eliminated for a considerable number of days; and 3. If a significant number of persons elect to be managed by EDAM in a given year, a partial refund of premiums would encourage consumer awareness and support.

Doctor Williams is a general surgeon.

Doctor Mandell

By Gerald H. Mandell, MD
Detroit

Any discussion of escalating medical costs must consider cost effectiveness. The problem is not how much money is spent but rather how it is spent. Major advances in diagnosis, treatment and accessibility of care have resulted from large expenditures for health by the private sector through insurance, and by government, through funds for hospital construction, medical research, and Medicare and Medicaid.

In the past 30 years there have been marked declines in tuberculosis, poliomyelitis, whooping cough and rubella. In the past several years there has been a significant reduction in infant mortality; cerebral and cardiovascular diseases have declined by 14%. Our population is living longer and is healthier than ever before.

From my viewpoint as a hospital-based pathologist, the technical advances are impressive. Recent innovations include renal transplantation, coronary bypass surgery, intensive care, advances in immunology, cytogenetics, toxicology, electron microscopy, chemotherapy, radiation therapy, antibiotic therapy, isotope techniques for diagnosis and treatment, scanning devices and monitoring devices of diverse types.

These certainly are miraculous developments but by no means gifts from heaven. Rather, these accomplishments are a result of the public's willingness to bear the costs involved for the benefits derived.

Is now the time for us to no longer seek these benefits, or shall we be true to our cause as physicians and continue to direct our energies for the public good? As doctors, we have no choice in the matter; our course is clear. The public has the power to direct its destiny, but we, as citizens, have an obligation to guide the public in determining life's priorities.

Excessive costs are real and their causes must be addressed. Current control measures include peer review, tighter budget control, reducing inefficient hospital services, requiring certificates of need, using area-wide planning of health resources and reducing fraud.

Two major causes of high health care costs, however, cannot be controlled by any of these measures. The first is inflation (a 50 percent rise in prices since 1971), and the second, the desire to provide greater access to health care. Some people, Senator Kennedy, for example, believe that access to health care is far from satisfactory despite the fact that *total* access at *all* times either is paradise or a planner's pipe dream. Alas, we do not live in heaven and pipe dreams vanish rapidly in the face of reality.

To this end, I propose the following: medical education should be broad-based. We should make a concerted effort to have a nation of well-informed people. Members of the public should be able to participate fully in decisions that affect their lives collectively and individually. Information on health matters should be given freely and supported by the finest of our practitioners. Health education should begin in the primary grades and continue through college. Simple diagnostic equipment can be made available to the public, for example, thermometers, sphygmomanometers, tongue blades, otoscopes, dipsticks for urinalysis, etc. Techniques for first aid should be widely taught. Principles of hygiene and preventive medicine must continue to be stressed.

Is public education in medicine feasible? I believe it is. An aware public can contribute to healthful living and support us in providing superior care for all.

Doctor Mandell is associate chairman, Department of Laboratory Medicine, Sinai Hospital of Detroit.

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References
*National Disease & Therapeutic Index, Jan.-Dec., 1976 IMS America Ltd., Ambler, Pa 1976.
†Amer. Med. Assn., Dept. of Drugs, A.M.A. Drug Evaluations, 2nd Edition, Publishing Sciences Group, Inc. Acton, Mass., 1973, pp 482-3.

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" . . . new vision care program . . . unfair and discriminatory to both patients and physicians."

I write you as an ophthalmologist who has practiced in Lansing for six and a half years and whose future type and continuation of practice may be significantly changed by the increasing problems with the Blues and Medicaid and to some extent with other third party carriers.

The new vision care program by the Blues, which discriminates against non-participating physicians, is obviously unfair and discriminatory against both patients and physicians. I am and will continue to resist this type of discrimination with all the power at my command. This is obviously another example of the effort by the Blues and other third party carriers to control the quantity, quality and cost of medical care themselves. The apparent direction of this effort is to take these matters completely out of the hands of practicing physicians. As a member of the Ingham County Medical Society, MSMS and AMA, I strongly urge you to oppose this discrimination against non-participating ophthalmologists.

Careful analysis of the above problems makes it apparent that this type of outside control, without physician consultation and negotiation, will spread to all of medicine and will lead to the logical conclusion that medical care, physicians and patients will be controlled completely by insurance companies and government. I feel strongly that this will lead to not only poor patient care but also greatly increased medical costs because of over-utilization by patients. This latter matter is already very apparent in my practice.

James S. Close, MD
Lansing

" . . . our appreciation for quick, decisive action re: BCBSM."

The members of our group would like to express our appreciation for your quick and decisive action in regards to the recent program announced by the Blue Cross Blue Shield of Michigan. We were all appalled at their new policies and we believe they are discriminatory, unfair and possibly illegal.

We would, therefore, like to express our full support for any and all efforts to refute these policies.

Thank you again for doing such an outstanding job in representing the physicians of this State.

Mark W. Harrold, MD
Lansing

" . . . especially intrigued by (emerging medicine) portion of report."

I have just reviewed Mr. John Anthony's article in the June issue of *Michigan Medicine,* relating to the recent malpractice situation.

Inasmuch as I am in the full-time practice of emergency medicine, I was especially intrigued by that portion of the report. It was surprising to me to see that such a high incidence was relegated to the "emergency room" at the "place of injury." Most of the studies that I have seen placed malpractice suits orginating in emergency department settings as a very small percentage of the total. The Maryland study is the most prominent one which comes to mind.

Another interesting statistic is the 12.9% incident "place of injury rate" in the "emergency room" versus the 1.3% claim rate against those physicians practicing emergency medicine as a specialty. If I am interpreting this right, this means that the full-time emergency physician incidence of actual claims is less than tenfold that of other physicians who engage in emergency department practice. I would appreciate comment from the author in this regard and commend him on a well-written article.

William H. Johnson, MD
President, Michigan Chapter
American College of
Emergency Physicians

(Editor's Note: In reply to Doctor Johnson's questions, Michigan data on the emergency room as the place of injury are indeed slightly higher than national figures. But, as the article cautioned, many factors must be taken into consideration in interpreting the data. The reader must not compare the number of emergency physicians listed with the number of ER physicians named in suits, as many physicians working in the emergency room still indicate their specialties as other than emergency medicine.

" . . . need, rather than want, would be better term . . . "

Should the medical profession really take the lead in helping people decide what they *want* in the way of medical care, as outgoing MSMS President Leitch declared in his speech to the House of Delegates? I think that *need* rather than want would be a better term for physicians to use in this regard.

The confusion of these terms is largely responsible for the soaring demands for, and cost of, medical care. Our liberal legislatures would promise the public anything it wants to achieve their goal of government control of Medicine. Fulfilling their promise will bankrupt the system.

Only the physician can intelligently help the people decide what they need in the way of medical care. That, after all, is his primary concern.

Only by satisfying needs, rather than wants, will we be able to control costs.

Eugene Mezger, MD
Detroit

Doctor Weston continuing MSU's patient-oriented philosophy

The patient-oriented, family-care philosophy that has guided MSU's College of Human Medicine in its first 13 years is being carried on by new CHM Dean Donald W. Weston, MD.

Doctor Weston succeeded MSU's first medical school dean, Andrew D. Hunt, Jr., MD, who is now acting director of the MSU Office of Health Services. Doctor Hunt now supervises all university health services including those in the Clinical Center, and MSU health care facility open to the public.

Doctor Weston had served as acting dean since September, 1976, when Doctor Hunt took his new position. Prior to accepting the MSU deanship, Doctor Weston was associate dean and professor of psychiatry and health services education and research.

He is a pediatrician and psychiatrist. Since coming to MSU from California in 1968, he has been actively involved in community health and health planning. He spearheaded development of the innovative UP Medical Education Program, which trains family doctors in small-town doctors' offices and hospitals, and will graduate its first MDs in 1978. He has worked on programs for adolescents, migrant workers and the mentally ill.

Doctor Weston in 1976 earned a master of science in management degree with the Sloan School of Management at the Massachusetts Institute of Technology. He holds government consulting positions with the National Institute of Mental Health's Bureau of Health Manpower. He is on the editorial advisory board of "Administration in Mental Health," and consults for the Alcoholism Drug Abuse and Mental Health Administration.

Doctor Weston is a graduate of the University of Southern California medical school.

Doctor Weston

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Health department conducting long and short-term PBB study

The Michigan Department of Public Health is engaged in a number of projects related to the effects of PBB on human health.

Long-term study of those with symptoms

Intensive medical evaluations of people who have had symptoms which could be related to PBB now are being arranged by the MDPH as part of the Department's PBB long term study.

Approximately 50 persons in all will be studied. These evaluations are being done at both University Hospital in Ann Arbor and at Henry Ford Hospital in Detroit.

The purpose of this medical evaluation program is to find out what can improve the health of individuals having illnesses associated with exposure to PBB, according to Kenneth Wilcox, MD, Chief, Bureau of Disease Control & Laboratory Services. "Since the health effects of PBB must be defined accurately to determine what treatments should be developed, many studies of a specified nature will be done in addition to those that would ordinarily be carried out on patients seeking medical care.

"If the health problems are due to PBB, the only hope we have of doing something about them is by such special studies to find out how PBB causes problems in the body," says Doctor Wilcox.

The National Center for Disease Control visited 19 farm families in Michigan earlier this year and recommended intensive medical evaluations of a number of people exposed to PBB. The CDC now is working in conjunction with the Health Department on the PBB long-term health study.

(The following is excerpted from a recent letter to an MSMS member. The letter was written by MSMS President Vernon V. Bass, MD, Saginaw.)

What specifically has MSMS done about the PBB problem?

1. MSMS has had staff monitoring developments and maintaining liaisons with governmental agencies and others concerned.
2. MSMS has maintained close contact with MSMS members working on the matter to arrive at a considered opinion and position.
3. MSMS offered a scientific program on the effects of PBB and other related chemical products at the 1976 MSMS Scientific Session at the Hyatt Regency. Invitations to attend this session were sent to a wide spectrum of news media. Several radio, TV, and newspaper reporters conducted interviews with the coursé lecturers.
4. At the MSMS Council midsummer meeting in July, The Council heard the special report of our Committee on Public and Environmental Health and approved its recommendation "that the MSMS support the efforts of the MDPH in its continuing studies of PBB contamination in Michigan." This folows a complete review of the situation by Maurice Reizen, MD, director, MDPH, before the Council in May.

PBB relationship to lymphocyte function

Seventy to 100 people enrolled in the Department's PBB long-term study also are being examined to determine the relationship between PBB levels in the blood and the lymphocyte function. Recent information suggests people may have experienced some suppression of immune response to infectious disease as a result of PBB ingestion. Blood specimens will be drawn from each subject and sent to University Hospital in Ann Arbor for analysis.

Statewide sampling of general population

In addition, preliminary arrangements have been made for a statewide sampling survey to determine possible effects of PBB exposure on human health.

Under present planning, the study is to get underway early in 1978 with an initial report of medical findings expected by the end of next September.

Governor Milliken has asked the Legislature to authorize $1.5 million for the study to determine the extent and nature of possible PBB health effects in the general population of Michigan. The Governor said he expects the federal government to provide substantial funding for the legislative appropriation through the Department of Health, Education, and Welfare.

Under plans developed at the Governor's request by the MDPH, separate parts of the statewide study will be conducted by the School of Public Health of the University of Michigan and the Environmental Sciences Laboratory of Mount Sinai School of Medicine in New York. The Mount Sinai group will conduct the clinical field tests at selected sites throughout the state, while the School of Public Health team will carry out enrollment and baseline health interviews of those taking part.

Working with the School of Public Health, the Survey Research Center of the University of Michigan's Institute for Social Research will select the statistical sample for the investigation to provide a representative

Output and Retention of Graduates

YEAR	SCHOOL	GRADUATES	GRADUATE YEAR I IN MICHIGAN	PERCENT
1972	WSU	127	77	61 %
	UM	190	83	44
	MSU-CHM	31	15	48
		348	175	50 %
1973	WSU	121	82	68 %
	UM	204	82	40
	MSU-CHM	34	13	38
		359	177	49 %
1974	WSU	168	115	68 %
	UM	217	85	39
	MSU-CHM	55	24	44
		440	224	51 %
1975	WSU	207	131	64 %
	UM	230	95	41
	MSU-CHM	75	39	52
		512	265	52 %
1976	WSU	239	155	63 %
	UM	219	94	43
	MSU-CHM	86	42	49
		544	291	53 %
1977	WSU	250	158	63 %
	UM	230	102	46
	MSU-CHM	91	41	48
		571	301	53 %

(Editor's note: The above statistics were gathered by the Michigan Medical School Council of Deans through admissions offices of the state's three medical schools. It is difficult to draw conclusions from these figures, as many physicians trained in Michigan schools go out of state for internships and residencies, then return to Michigan to practice.)

PBB / *Continued*

cross-section of the Michigan population.

Personnel of the Federal Center for Disease Control at Atlanta, Georgia, and other DHEW agencies are also collaborating with the state health department in the project.

The general population survey is one in a series of PBB studies dating back to 1974. Other studies are:

— the 1974 quick survey of quarantined farms;

— the original short-term study — a statistically valid random sample of 300 persons out of a total affected population of several thousand;

— the development and implementation of a long-term study (in cooperation with the Center for Disease Control);

— the analysis of specimens sent in by physicians;

— the department's initial breast milk study and the subsequent, statistically valid random sample of mothers' milk;

— a Sept. 15-16 clinic in Muskegon for children born of mothers from PBB quarantined farms.

Other studies include intensive medical evaluations of selected ill farmers, lymphocyte studies among farmers, and a chemical workers' study.

One-third of California doctors with MD insurance firms

A recent California Medical Association Report on Professional Liability made the following major points:

(1) Approximately one-third of California physicians now are covered by doctor-owned malpractice insurance companies which began offering coverage during 1974-1977.

(2) Of those surveyed, 13.5 percent claimed they are "going bare." This number has increased from 1.6 percent in late 1974, but is below the high of 16.1 percent reporting no insurance in May, 1976.

(3) One-fourth reported making no changes in their mode of practice due to the liability crisis, but two-thirds of the general practitioners (especially in rural areas) reported dropping maternity services because of the cost of insurance.

(4) Most (three-quarters) of the physicians plan on renewing their insurance at the present level of protection.

(5) Only 11.1 percent are using arbitration in any form. One-third of those not using arbitration cited administrative difficulties and another one-third doubted the legality of the system.

These figures were derived from a representative sampling, but are not necessarily true of all physicians in California.

Meetings

(See also listing of Category I programs on page 576)

Nov. 29-30 – "Basic Principles of Reality Therapy," sponsored by Michigan State University School of Social Work and Continuing Education Service, at Western Michigan University, Kalamazoo, contact: Bert Thomas or Douglas Miller, School of Social Work, MSU, East Lansing, 48824, 517/353-8616.

Nov. 30-Dec. 1 – "Basic Principles of Reality Therapy," sponsored by MSU School of Social Work and Continuing Education Service, at Lansing Civic Center, Lansing, contact: Bert Thomas or Douglas Miller, School of Social Work, MSU, East Lansing, 48824, 517/353-8616.

Dec. 1 – "Basic Principles of Reality Therapy," sponsored by Michigan State University School of Social Work and Continuing Education Service, at Central Michigan University, Mt. Pleasant, contact: Bert Thomas or Douglas Miller, School of Social Work, MSU, East Lansing, 48824, 517/353-8616.

Dec. 1 – "Travel Programs for Retirees," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

Dec. 2 – "Basic Principles of Reality Therapy," sponsored by Michigan State University School of Social Work and Continuing Education Service, at Cobo Hall, Detroit, contact: Bert Thomas or Douglas Miller, School of Social Work, MSU, East Lansing, 48824, 517/353-8616.

Dec. 8 – "Trust Funds," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

Dec. 10-13 – AMA Winter Scientific Meeting, Miami Beach.

Dec. 14 – MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS Director.

Jan. 12 – "Post Retirement Employment Opportunities for Physicians," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

Jan. 25 – MSMS Council, MSMS Headquarters, contact: Warren Tryloff, MSMS Director.

Jan. 25 – MSMS/INTRAV South American Adventure, contact: Marçe Ireland, MSMS headquarters.

Feb. 9 – "Investments for Retirement Income," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

March 8 – MSMS Council, MSMS headquarters, contact: Warren Tryloff, MSMS Director.

March 8-9 – Michigan Conference on Maternal and Perinatal Health, Hyatt Regency Dearborn, contact: Herbert Auer, MSMS Headquarters.

April 13 – "The Physician's Family," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

May 5-7 – Annual MSMS House of Delegates meeting, Hyatt Regency Dearborn, contact: Dick Campau, MSMS Headquarters.

May 5-7 – MSMS Council, Hyatt Regency Dearborn, held in conjunction with the Annual MSMS House of Delegates meeting, contact: Warren Tryloff, MSMS Director.

June 15 – "Insurance Programs for Family Protection and Retirement Income," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

June 17-22 – AMA Annual Meeting, St. Louis.

Sept. 14 – "Legal Problems of Ending Medical Practice," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

Oct. 12 – "Pre and Post Retirement Medical Care for the Physician and His Family," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

Nov. 23 – "How Do I Know When to Retire?" presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

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Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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East Lansing 48823

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Manistee 49660

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Mt. Clemens 48044

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Pontiac 48053

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(Continued on page 574)

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[1] Goldberg HL, Finnerty RJ, Cole JO: Doxepin: Is a single daily dose enough? *Am J Psychiatry* 131:1027-1029, 1974.

Brief Summary of Prescribing Information
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Dosage and Administration—In mild to moderate anxiety and/or depression: 10 mg to 25 mg t.i.d. Increase or decrease the dosage according to individual response. **Usual optimum daily dosage is 75 mg to 150 mg** per day, not to exceed 300 mg per day.

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> ***Usage in Pregnancy:*** **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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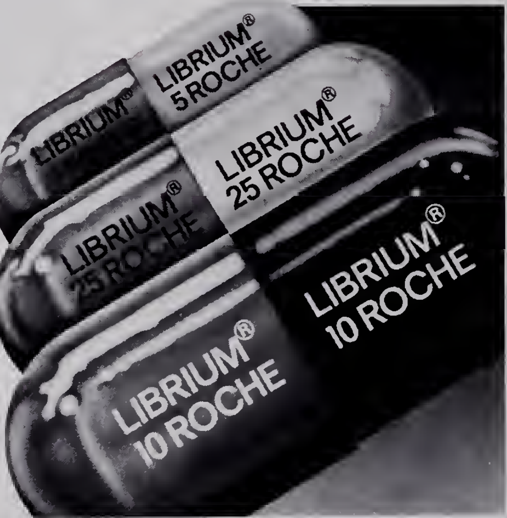

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Please see preceding page for a summary of product information.

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Davison 48423

MSMS membership at all-time high

MSMS membership has reached an all-time high in 1977. As of October, there were 8,861 paid members on the rolls.

MSMS actively recruits new members through special mailings to newly-licensed physicians. Benefits of MSMS membership are detailed in the booklet, "MSMS at Work," which is enclosed in the mailing. The MSMS Task Force on Membership, led by Kenneth J. Ray, MD, is currently planning efforts to boost the rolls even higher.

Physicians wishing to join MSMS must first join their county medical societies.

These, then, are their benefits:

(1) They are part of a unified physician force throughout the state, (2) They are represented and influential in state and national governmental programs, (3) They can speak in an organized manner to the public and to other health organizations, (4) They can participate in state-society sponsored continuing medical education programs at special members' rates, (5) They receive the monthly *Michigan Medicine* and semi-monthly *Medigram* newsletters, (6) They are eligible for MSMS group insurance plans and (7) They can join MSMS-sponsored group travel/study tours.

Further information is available from the MSMS Department of Member Services.

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Category I Courses

Michigan Medicine *each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351*

The following have been accredited directly by the AMA or by MSMS Commission on Continuing Medical Education:

Organizations:

American Association for Hand Surgery, Warren
American College of Emergency Physicians, Lansing
American College of Psychiatrists, Southfield
American Society of Colon and Rectal Surgeons, Detroit
Ann Arbor Psychiatric Association
Commission Professional and Hospital Activities, Ann Arbor
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan State University College of Human Medicine, East Lansing
Michigan Chapter, American Academy of Pediatricians, Detroit
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Society of Anesthesiologists
Noah Worcester Dermatological Society, Detroit
Section on Gastroenterology, American Society for Gastroenterology, Detroit
University of Michigan Medical Center, Ann Arbor
University of Michigan School of Public Health
Wayne State University School of Medicine, Detroit

Hospitals:

Alma-Gratiot Community Hospitals, Alma
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Little Traverse Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie
Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Cottage Hospital of Grosse Pointe
Detroit-Macomb Hospital Association
Ferguson-Droste-Ferguson Hospita Grand Rapids
Grace Hospital, Detroit
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo State Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital), Muskegon
Marquette General Hospital
McLaren General Hospital, Flint
Mercy Hospital, Port Huron
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Oakland Medical Center, Pontiac
Oakwood Hospital, Dearborn
Pontiac General Hospital, Pontiac
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals, Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Edward Sparrow Hospital, Lansing
Traverse City State Hospital, Traverse City
V. A. Hospital, Battle Creek
Wayne County Psychiatric Hospital, Eloise
West Shore Hospital, Manistee
Ypsilanti State Hospital, Ypsilanti

Date: **Nov. 16, Diseases of the Biliary Tract. Location:** St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** All specialties. **Contact:** Department of CME, St. John Hospital, Detroit (313) 881-8200, ext. 321. **Approved for:** 7 hours of Category 1 Credit.

Date: **Nov. 16, "New Concepts in Neurology and Neurosurgery — A Course for Primary Physicians." Location:** Hoffman House, Grand Rapids. **Sponsor:** Blodget Memorial Medical Center. **For:** Primary physicians. **Cost:** $35. **Contact:** Oliver Grin, MD, Blodgett Memorial Medical Center, 1890 Wealthy SE, Grand Rapids, 616/456-9507. **Approved for:** 7 hours of Category 1 Credit.

Date: **Nov. 17, Psycho-Pharmacology. Location:** Towsley Center for Continuing Medical Education, University of Michian Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $60. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 7 hours of Category 1 Credit.

Date: **Nov. 26-30, Ophthalmology Review. Location:** Dearborn Inn. **Sponsor:** WSU-Department of Ophthalmology. **For:** Ophthalmologists. **Cost:** $350. **Contact:** WSU Division of CME, Room 1209 Scott Hall, 540 East Canfield, Detroit 48201. **Approved for:** 40 hours of Category 1 Credit.

Date: **Dec. 2, Care of the Burned Patient. Location:** Towsley Center for Continuing Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-Sponsor:** University of Michigan Burn Center and National Institute for Burn Medicine. **Cost:** $15. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 6¾ hours of Category 1 Credit.

Date: **Dec. 3, Seminar in Ophthalmology for the Primary Care Physician. Location:** Detroit Institute of Ophthalmology, 15401 E. Jefferson, Grosse Pointe Park, 48230. **Co-Sponsors:** DIO and Bon Secours Hospital. **For:** All specialties. **Cost:** $50. **Contact:** Judi Dara, 313/824-4710. **Approved for:** 5 hours of Category 1 Credit.

Date: **Dec. 10, "Needle Aspirations" Seminar. Location:** University of Michigan, Ann Arbor. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** John F. Dunkel, MD, Department of Pathology, Michigan State University, East Lansing 48823 or James W. Landers, MD, Department of Pathology, St. John Hospital, Detroit. **Approved for:** 3 hours of Category 1 Credit.

Date: **December 10, A Practical Course and Workshop on Indirect Ophthalmoscopy and Peripheral Retinal Anatomy and Pathology. Location:** Kresge Eye Institute. **Sponsor:** Kresge Eye Institute. **Co-Sponsor:** Wayne State University. **For:** Ophthalmologists. **Cost:** $20. **Contact:** Harold Weiss, MD, Course Director, Kresge Eye Institute, 3994 John R., Detroit, 48201, 313/557-1320. **Approved for:** 4 hours of Category 1 Credit.

Date: **Feb. 5-10, Michigan-Indiana Family Practice Update. Location:** Boyne Highlands. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-Sponsor:** Michigan Academy of Family Physicians-Indiana Academy of Family Physicians. **Cost:** $175 for physicians, $90 for physicians-in-training. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education*. Approved for 21½ hours of Category 1 Credit.

Date: **Feb. 10-11, Topics in Adult Psychiatry. Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education*. **Approved for:** 11¼ hours of Category I Credit.

Date: Feb. 14, Sexually Transmitted Diseases. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education*. **Approved for:** 7 hours of Category I Credit.

Date: Feb. 20-24, Emergency Medicine. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-sponsor:** American College of Emergency Physicians. **Cost:** $225 for physicians, $125 for physicians-in-training. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education*. **Approved for:** 36¼ hours of Category I Credit.

Date: Feb. 28, Continuing Pathology Conference. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $20. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education*. **Approved for:** 6½ hours of Category I Credit.

Date: March 8-10, Hemotology Review. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education*. **Approved for:** 21 hours of Category I Credit.

Date: March 16-17, Newer Concepts in Gastrointestinal Surgery. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $130. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education*. **Approved for:** 14 hours of Category I Credit.

Date: March 22-23, Advances in Pediatrics. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $120. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 14 hours of Category I Credit.

Date: March 30-31, The Spine and Spinal Cord. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education*. **Approved for:** 14 hours of Category I Credit.

Date: April 6-7, Ophthalmology Conference. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education*. **Cost:** $140. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 14 hours of Category I Credit.

Date: April 12-13, Symposium on Child Development. Location: Western Michigan University, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association. **Co-sponsor:** SMAHEC. **For:** Pediatricians, family practitioners, obstetricians. **Contact:** Valerie Lincoln, RN, Perinatal Coordinator, Bronson Hospital, 252 E. Lovell, Kalamazoo, 49007.

Date: April 14-15, The Wayne State University School of Medicine 11th Annual Cancer Symposium, "Cancer of the Colon and Rectum." Location: Gordon H. Scott Hall, 540 E. Canfield, Wayne State University, School of Medicine, Detroit 48201. **Sponsor:** Wayne State University. **Co-sponsor:** American Cancer Society, Michigan Division. **For:** Primary care physicians. **Cost:** $50. **Contact:** Melvin L. Reed, MD, FACP, Associate Professor, Department of Oncology, 4160 John R., Detroit 48201. **Approved for:** 12 hours of Category I Credit.

Date: April 17-21, Family Practice Review II. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-Sponsor:** Michigan Academy of Family Physicians. **Cost:** $250. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education*. **Approved for:** 37 hours of Category I Credit.

Date: April 25, Continuing Pathology Conference. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $20. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education*. **Approved for:** 6½ hours of Category I Credit.

Date: May 4-5, The High-Risk Infant. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $75. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 12 hours of Category I Credit.

Date: May 22-26, Internal Medicine. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $250. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education*. **Approved for:** 33½ hours of Category I Credit.

Date: June 25-30, Northern Michigan Summer Conference. Location: Shanty Creek Lodge, Bellaire. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $200. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 21½ hours of Category I Credit.

Continuing Courses

Date: Continuing Quarterly Journal Club — Surgery. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Surgeons. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Monthly, Cleft Palate Clinic. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital****. **For:** Oral Surgeons, plastic surgeons, pediatricians. **Cost:** None. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 3 hours of Category I Credit.

Date: Monthly, Tissue Audit (Cancer). Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Surgeons, ob-gyns, pathology, radiology. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 2 hours per session Category I Credit.

Date: Monthly Lecture Series in Ophthalmology. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Ophthalmologists. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Monthly, Ob/Gyn Journal Club. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** All interested physicians. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Monthly Urology Journal Club. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Urologists. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital**** **Approved for:** 2 hours of Category I Credit.

Date: Begins September, Continuing Training in Family Therapy. Location: Suite 1212, North Park Plaza, 17117 W. Nine Mile Road, Southfield. **Sponsor:** Family Institute of Southeastern Michigan. **Co-sponsor:** Ackerman Institute. **For:** Psychotherapists. **Cost:** Varies according to time put in. **Contact:** Carolyn R. Tourkow, MSW, director, Family Institute of Southeastern Michigan. **Approved for:** Hours vary with time spent.

Date: Every Tuesday — Psychiatry — Special Problems Seminar. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Psychiatrists. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Every Tuesday morning, Gynecology/Obstetrics Combined Grand Rounds. Location: Jackson Auditorium, Hutzel Hospital. **Sponsor:** Wayne State University Department of Gynecology-Obstetrics. **For:** All interested

CATEGORY I / *Continued*

physicians. **Cost:** No charge. **Contact:** Wayne State University, Division of CME**. **Approved for:** 4 hours each of Category I Credit.

Date: Each Wednesday, Detroit Medical Center Hand Conference. Location: Classroom 3, Second Floor, Webber Wing, Harper Hospital, Detroit. **Sponsor:** Wayne State University. **For:** Surgeons. **Cost:** No charge. **Contact:** Joseph L. Posch, MD, Fourteenth Floor, Kales Building, 76 W. Adams, Detroit 48226. **Approved for:** Hour-for-hour Category I credit.

Date: Second Thursday of each month, Inter-Hospital Pathology Slide Conference. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** Pathologists. **Cost:** No charge. **Contact:** Department of CME, St. John Hospital, 22101 Moross Road, Detroit, 48236, (313) 881-8200. **Approved for:** 3 hrs. each date Category I Credit.

Date: Saturdays — Intermediate Training in Family Therapy. Location: Northland Clinic, Southfield. **Sponsor:** The Family Institute of Southeastern Michigan. **Co-Sponsor:** Ackerman Family Institute of New York. **For:** Psychiatrists. **Cost:** $25 per session. **Contact:** Carolyn R. Tourkow, MA, MSW, Suite 1212, North Park Plaza, 17117 West Nine Mile Road, Southfield 48075. **Approved for:** 3½ hours of Category I Credit.

Date: Saturdays, Morbidity and Mortality Conference. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital Department of Surgery. **For:** Surgeons. **Cost:** None. **Contact:** Office of CME, Sinai Hospital of Detroit**** **Aproved for:** 2 hours of Category I Credit per session.

Date: Every Saturday, Weekly Conference. Location: Gamble Building, Burns Clinic/Little Traverse Hospital, Petoskey. **Sponsor:** Burns Clinic/Little Traverse Hospital. **For:** All interested physicians. **Cost:** None. **Contact:** Ernest W. Carpenter, MD, 560 West Mitchell, Petoskey, 49770.

Date: Every Saturday, Weekly Conference. Location: Gamble Building, Burns Clinic / Little Traverse Hospital, Petoskey. **Sponsor:** Burns Clinic. **For:** All interested physicians. **Cost:** None. **Contact:** A. D. Damschroder, MD, Chairman, Burns Clinic Medical Center, Petoskey 49770. **Approved for:** Hour-for-hour Category I Credit.

Date: Saturdays, Intensive Training in Family Therapy. Location: Southfield. **Sponsor:** The Family Institute of Southeastern Michigan. **Co-Sponsor:** Ackerman Family Institute of New York. **For:** Psychiatrists. **Contact:** Carolyn R. Tourkow, MA, MSW, Suite 1212, North Park Plaza, 17117 West Nine Mile Road, Southfield, 48075.

Date: Fall, 1977, Intermediate Training in Family Therapy — "Skills and Implements of Family Therapy." Location: Ann Arbor. **Sponsor:** The Family Institute of Southeastern Michigan. **Co-sponsor:** Ackerman Family Institute of New York. **For:** Psychiatrists. **Cost:** None. **Contact:** Carolyn R. Tourkow, MA, MSW, Suite 1212, North Park Plaza, 17117 West Nine Mile Road, Southfield, 48075. **Approved for:** 9 hours of Category I Credit.

Date: Fall, 1977, Intermediate Training in Family Therapy — Improving Communication Skills. Location: Southfield. **Sponsor:** The Family Institute of Southeastern Michigan. **Co-Sponsor:** Ackerman Family Institute of New York. **For:** Psychiatrists. **Cost:** $75. **Contact:** Carolyn R. Tourkow, MA, MSW, Suite 1212, North Park Plaza, 17117 West Nine Mile Road, Southfield, 48075. **Approved for:** 9 hours of Category I Credit.

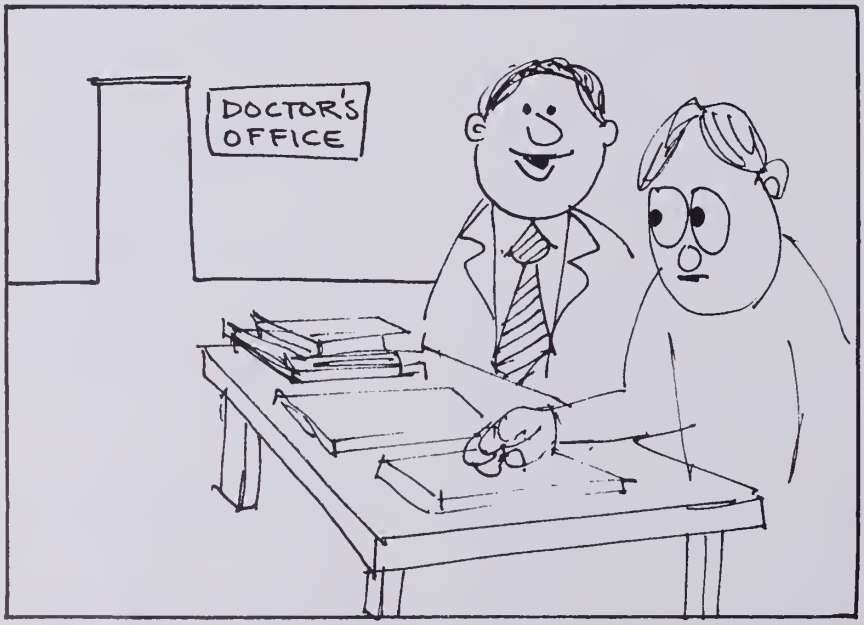
Date: Wednesdays, Nov. 2, 9, 16, 23, Psychiatry and Self-Regulation: Biofeedback and the New Cognitive Therapies. Location: Zuckerman Auditorium, Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital of Detroit. **Co-Sponsor:** Michigan Psychiatric Society Rotating Lecture Series. **For:** Psychiatrists. **Cost:** $25. **Contact:** 313/493-6212. **Approved for:** 6 hours of Category I Credit.

Date: Thursdays, through December, Current Ophthalmology. Location: Kresge Eye Institute, 3994 John R., Detroit. **Sponsor:** Kresge Eye Institute of Wayne State University. **For:** Practicing ophthalmologists. **Cost:** None. **Contact:** Kresge Eye Institute of Wayne State University Detroit. **Approved for:** 2 hours of Category I Credit.

Date: Monthly, Saturdays - Sundays, Intensive Training in Family Therapy. Location: Southfield. **Sponsor:** The Family Institute of Southeastern Michigan. **Co-Sponsor:** Ackerman Family Institute of New York. **For:** Psychiatrists. **Cost:** $2,500 per year. **Contact:** Carolyn R. Tourkow, MA, MSW, Suite 1212, North Park Plaza, 17117 West Nine Mile Road, Southfield, 48075. **Approved for:** 120 hours of Category I Credit (must go to all sessions).

Date: Monthly, Saturdays, Intermediate Training in Family Therapy. Location: Southfield. **Sponsor:** The Family Institute of Southeastern Michigan. **Co-Sponsor:** Ackerman Family Institute of New York. **For:** Psychiatrists. **Cost:** $25. **Contact:** Carolyn R. Tourkow, MA, MSW, Suite 1212, North Park Plaza, 17117 West Nine Mile Road, Southfield, 48075. **Approved for:** 3 hours of Category I Credit.

Date: Jan. 4, 11, 18, 25; Feb. 1 & 8, 1978, Forensic Psychiatry for the Non-Forensic Psychiatrist. Location: Fisher Auditorium, Providence Hospital, Southfield. **Sponsor:** Providence Hospital. **Co-Sponsor:** The Michigan Psychiatric Society Rotating Lecture Series. **For:** Psychiatrists. **Cost:** $25. **Contact:** 313/493-6212. **Approved for:** 9 hours of Category I Credit.



"Which magazine would you like? The 1953 National Geographic, A 1956 Look Magazine or The 1961 Reader's Digest with the cover missing?"
(cartoon by Mark Campbell, MD, Grand Rapids)

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*Office of Intramural Education, University of Michigan Medical Center, Dep't. of PBM/HPE, Ann Arbor, 48109.

**WSU Division of CME, Room 1209, Scott Hall, 540 E. Canfield, Detroit, 48201 (313) 577-1453

***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902

****Department of CME, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 493-5097.

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Life planning for physicians course continues in Detroit

Ten sessions on "Life Planning for Physicians" are planned during the coming year at St. John Hospital, Detroit. The series is presented by the hospital's Department of Health Education in cooperation with Wayne County Medical Society.

First session, on estate planning for physicians, took place Sept. 8. All succeeding sessions are in the Whyte Memorial Auditorium, Education Center, St. John Hospital, 22101 Moross, Detroit, 48236. The programs are not applicable for CME credit. No fees are charged. Attendance is limited to 200 participants, and reservations may be made with the hospital.

Other sessions, all of which take place on Thursday evenings from 7 to 9 p.m., are:

- Travel Programs for Retirees, Dec. 1
- Trust Funds, Dec. 8
- Post-Retirement Employment Opportunities for Physicians, Jan. 12
- Investments for Retirement Income, Feb. 9
- The Physician's Family, April 13
- Insurance Programs for Family Protection and Retirement Income, June 15
- Legal Problems of Ending Medical Practice, Sept. 14
- Pre- and Post-Retirement Medical Care for the Physician and Family, Oct. 12
- How Do I Know When to Retire? Nov. 23

Experts in the field will speak at each session, with physician panels scheduled for the last two meetings.

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The entire scientific program of the AMA Winter Meeting is specifically designed for physicians who recognize the need for multi-specialty continuing medical education. It offers a broad-based, cross-disciplinary learning experience which is not usually available at specialty society meetings.

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Program Highlights

59 Postgraduate Courses—This large selection of Category 1 courses allows you to concentrate on those areas in which you want to update and upgrade your medical knowledge and skills (See overleaf.)

2 Videoclinics, 6 Telecourses, 2 Motion Picture Seminars, 8 State of the Art Lectures, 9 Dialogues—All of these events are Category 1 and free of charge (except the videoclinics). It means you could earn up to 20 hours of Category 1 CME credit *without any cost to you.*

Scientific Exhibits—These presentations highlight research being done in medical schools, hospitals, and research institutes, and provide an ideal one-to-one learning experience.

Industrial Exhibits—More than 80 firms will exhibit an array of new products and services that are indispensable to medical practice.

See overleaf for complete listing of postgraduate courses

Dept of Meeting Services STJ
American Medical Association
535 North Dearborn St.
Chicago, Illinois 60610

Please send me complete information on the AMA 31st Winter Scientific Meeting.

Name ____________________

Address ____________________

City/State/Zip ____________________

Scientific Program

AMA 31st Winter Scientific Meeting

POSTGRADUATE COURSES
Category 1 (fee required)

Basic Electrocardiography
Thyroid Disease: Diagnosis and Management
Evaluation of Coronary Vascular Disease
Advances in Rheumatoid and Collagenous Vascular Disease: Diagnosis and Therapy
Fetal Assessments—Monitoring
Ophthalmology for the Nonophthalmologist
Medical and Surgical Management of Skin Cancer
Basic Life Support—CPR
Fluid and Electrolyte Balance
Hypoglycemia: Diagnosis and Management
Diagnosis and Treatment of Fractures of the Lower Extremities
Medical and Surgical Management of Coronary Vascular Disease
Noninvasive Diagnostic Radiological Techniques
Dermatology for the Nondermatologist
Sports Injuries
Biofeedback and Other Techniques
Clinical Aspects of Immunology
Diabetes: Diagnosis and Management
Psychotropic Drugs: Uses and Abuses
Unsticky Platelets—Loose Clots
Infectious Diseases in Children
Office Gynecology
Drugs: Actions, Reactions, and Interactions
Care of the Critically Ill: Medical and Surgical Management
Office Endocrinology
Newer Clinical Approaches to the Sexually Transmitted Diseases
Diagnosis and Treatment of Fractures, Dislocations, and Epiphyseal Injuries in Children
Advanced Life Support—Cardiopulmonary Resuscitation (CPR)
Medical and Emotional Problems of Aging
Hypercalcemia: Diagnosis and Management
Evaluation and Management of the Jaundiced Patient
Pediatric Feeding and Nutritional Problems
Office Neurology
Psychiatry for the Nonpsychiatrist
Indications for Total Joint Replacement
Management of Acute and Chronic Pulmonary Problems
Evaluation and Management of Hyperlipidemias
Emergency Medicine for 1978
Pediatric Allergy and Immunology
Management of Renal Failure
Management of Hepatic Problems
Diagnosis and Treatment of Fractures of the Upper Extremities
The Integration of Adjuvant Modalities in the Treatment of Cancer
Nephrolithiasis: Diagnosis and Management
Evaluation and Management of Arrhythmias
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*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

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Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

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WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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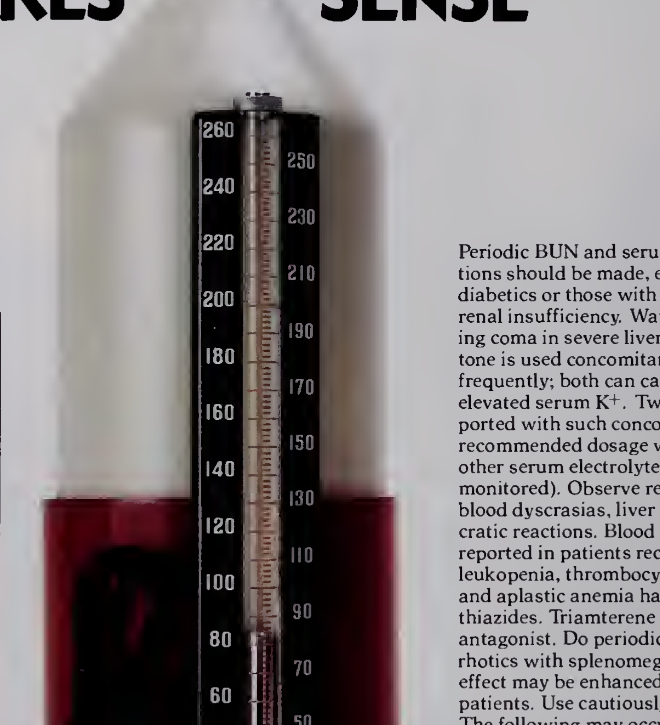

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This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

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Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K+ frequently; both can cause K+ retention and elevated serum K+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

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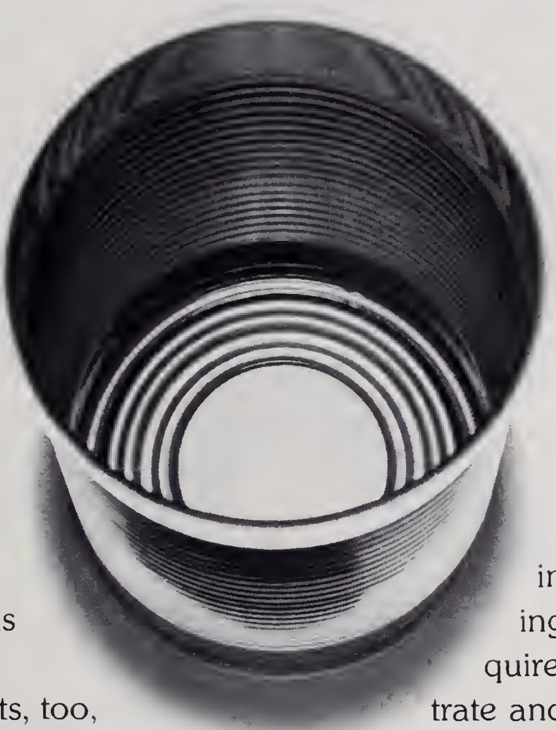

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Medicaid fee increases in effect

By Sherry Wellman
MSMS government agency liaison

The Michigan Department of Social Services has begun paying increased Medicaid fees for ambulatory services approved by the state legislature for fiscal year 1977-78. The result of intense negotiations over the past year, Medicaid fees have been raised to current Medicare levels for an average increase of 23 per cent for the majority of services provided by physicians.

Several important features of how the increased Medicaid payments were accomplished and how they are being implemented deserve to be highlighted.

Following the January, 1976 discounting of Medicaid fees by 11 per cent, and the subsequent position of MSMS that it could no longer encourage its members to participate in the Medicaid program, physician participation dropped dramatically. During the ensuing months, it became apparent that Medicaid patients were experiencing increased difficulty in obtaining necessary physician services and many were forced to resort to more costly facilities for medical care.

The MSMS Medicaid Liaison Committee, chaired by David Siegel, MD, of Lansing; the Michigan Department of Social Services; and key legislators from the House and the Senate agreed that it was necessary to entice physicians back into the Medicaid program to deliver needed services to Medicaid patients. A survey conducted by MSMS showed that low Medicaid fees were the primary reason why physicians were no longer accepting Medicaid patients. Additional information yielded the fact that existing Medicaid fees, without any percentage discounting, averaged some 23 per cent less than payments by Medicare. The elimination of this disparity between two governmental programs became the priority objective toward accomplishing the goal of greater physician participation in Medicaid. That goal was accomplished with the enactment of appropriations bill for the Department of Social Services containing additional funds in the physician line item and language stating, "On October 1, 1977, the Department shall increase fee screens for all physicians' services provided in an ambulatory setting to current Medicare levels."

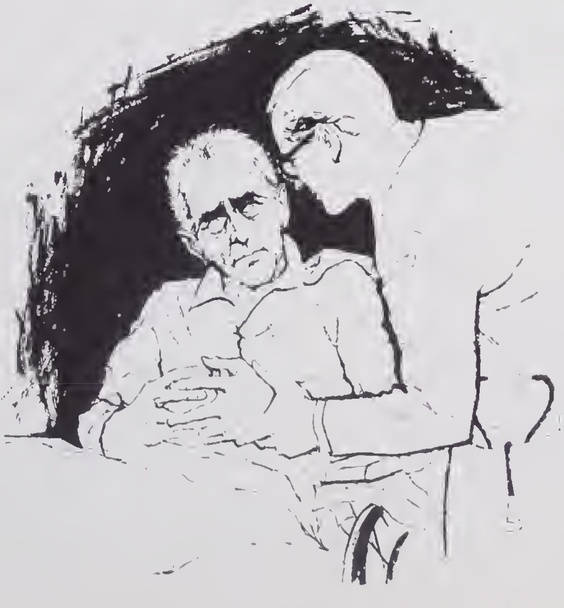
The following implementation schedule of the new Medicaid fees should be read carefully to assure full compensation for ambulatory services. The schedule was prepared by the Department of Social Services

---

Recipients' share of hospital costs up

The portion of hospital charges that Medicare recipients must pay has been boosted to $144 effective Jan. 1, the Department of HEW has announced. That represents a 16 percent rise in recipients' share.

The $20 boost is due to increased hospital costs that under law must be reflected in the Medicare recipient's initial payment. Hospital costs have been rising at about 15 percent, more than twice the overall inflation rate. When the Medicare program first took effect in 1966, the initial day's payment was $40.



MEDICAID / *Continued*

(MDSS) and reviewed by members of the Medicaid Liaison Committee.

Ambulatory care screen revisions

All procedure codes in the 0001 through 9999 range will be evaluated and appropriate revisions made to the maximum fee levels except those codes which are valid for "place of service 1" only (inpatient). This will cover approximately 80 per cent of all physicians' services to Medicaid patients. It is important to note that MDSS will pay different fees for those services which can be provided in either an ambulatory or inpatient setting depending on where the service is performed. Services provided on or after October 1 will be eligible for the increased fees only when provided in an ambulatory setting which must be indicated on the invoice by the "place of service."

Supplemental appropriations effective August 1

A separate supplemental appropriations bill increased the following services on August 1: (1) Office visits (9000 - 9049); (2) home visits (9050 — 9069); (3) long term care visits (9090 — 9119); and (4) injections (9700 — 9729).

Fiscal year appropriations effective October 1

All remaining ambulatory physicians' services will be revised with screens made effective October 1: (1) medicine (remaining ambulatory 9000); (2) ambulatory surgeries (0001 — 5999); (3) radiological services (7000 — 7999); and (4) pathological services (6500 — 6999) and (8000 — 8999).

Implementation schedule

All new screens were effective October 1, but due to the technical changes required to instruct the computer to pay the increases, various procedure codes will be updated according to the following schedule. Physicians may wish to hold invoices containing the last procedure codes until the effective date of change in order to receive the increased payments.

1.	**150 most common codes** ***This accounts for approximately 83% of the total dollar volume for physicians.***	**Sept. 30**
2.	**Remaining 9000 codes**	**Oct. 30**
3.	**0001 — 0499 (integumentary system)**	**Oct. 30**
4.	**0500 — 1999 (musculoskeletal system)**	**Oct. 30**
5.	**2000 range**	**Nov. 30**
6.	**3000 range**	**Nov. 30**
7.	**4000 range**	**Dec. 30**
8.	**5000 range**	**Dec. 30**
9.	**7000 range**	**Jan. 30**
10.	**8000 range**	**Jan. 30**

Screen revision methodology

The mandate to raise Medicaid fees to those of current Medicare screens applies to those procedures for which there is an "exact match" between Medicaid and Medicare. When there is a solid Medicare match, MDSS will pay the Medicare screen but price differentials between regionalized screens will remain the same. MDSS will go exactly to the Medicare screen for Region 3 and will increase Regions 1 and 2 to reflect the same differential which existed before. The Legislature also mandated MDSS to minimize regionalization of payments whenever possible, but where regionalization is required by Medicare, the Region 3 screen will not exceed the Region 2 screen and the Region 2 screen will not exceed the Region 1 screen, for individual procedures.

Where there are not solid matches between Medicaid and Medicare, those procedures will be raised by the overall percentage Medicaid fees are below current Medicare screens, approximately 23 per cent. To comply with the legislative directive, these procedures will be paid on a state-wide screen.

Doctor Siegel comments

"We think we have achieved what we set out to do. We have the language and the money to carry it out. For the first time since 1973, Michigan physicians will be receiving Medicare-level payments for the vast majority of Medicaid services. Now we believe physicians who have felt unable to accept new Medicaid patients will be able to do so.

"We wish to express our appreciation to those legislators who were helpful in achieving the new Medicaid policy of paying physicians at Medicare levels, particularly Reps. Raymond C. Kehres, Melvin L. Larsen, Joseph F. Young, and Senator Earl E. Nelson. In addition, John T. Dempsey, director of the Department of Social Services, made public his appreciation that MSMS is again encouraging its members to take part in the Medicaid program as a result of the fee increases.

"As the Medicaid Liaison Committee continues its work on behalf of all Michigan physicians, our 1978 position will be for complete use of Medicare screens for both ambulatory and in-patient services."

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Home birth: technology vs. togetherness

By Bruce A. Work, Jr., MD
Ann Arbor

Doctor Work

Over the past few years, there has been a renewed interest by some pregnant patients and their families in home deliveries. Although the number of actual patients seeking home delivery is small, the opposition from the medical profession is predictably strong.

The interest in home births has been stimulated by societal factors as well as economic factors. Over the past 15 years, society has gradually accepted the concept of "protesting the system" and questioning what was previously considered irrevocable authority. Organized medicine and the institutions that hospitals represent have fostered the concept of authority.

There is a desire for increased freedom from institutional restraints and a return to principles and concepts of our agrarian era when families were born, raised, fed and died in the home and/or farm environment. This has resulted in some patients seeking home deliveries. Perhaps too, there is an interest in seeking the different or atypical way of having a birth.

Economic factors also have caused some individuals to seek relief from high costs of medical care, including childbirth. Vulnerability occurs during times when health insurance lapses due to unemployment. It is not uncommon for hospital bills to range between $1,000 and $2,000 for hospital delivery and its attendant care. Home delivery, per se, is generally much less.

At the same time, improvements in maternal mortality over the past 50 years in this country have caused many patients to consider childbirth to be quite a safe process as well as a natural process. Progress in high-risk identification prior to onset of labor has permitted those not so identified to consider themselves completely normal. Such thinking is short-sighted.

Physicians' worries

Countering these points are the worries of many obstetricians and pediatricians who are fearful of unsatisfactory outcomes of pregnancy. Most physicians will agree with the concept that birth is a natural process. It is the speed with which catastrophic events can occur requiring intervention generally not available in the home environment that concerns most physicians. At least some of the reduction in maternal and perinatal morbidity and mortality can be attributed to technological advances including pharmaceutical advances that have been made over the past 50 years. The ability to identify high risk situations and preparing to intervene when indicated has no doubt been a factor. Complacency or satisfaction in the results achieved by this system cause physicians to want to maintain the status quo. Why change a winning combination?

Patients' perspective

If we place ourselves in our patients' shoes and ask the above question, then perhaps we will have a different perspective. The labor and delivery areas of our hospitals can be noisy, threatening, even terrifying environments for our patients. It is easy to forget the helplessness that a patient can feel when placed in a supine position, in pain, surrounded by strangers saying seemingly foreign words and making loud noises with metallic objects. Isolation from one's family and supposed normal newborn at such times only add to the anxiety. To attempt to quote percentages, risk factors, professional opinions also add to the anxiety of many of these patients.

We must consider how to bring the advances of technology to bear for the patient's benefit so that the patient feels comfortable with the technology that the medical team uses and doesn't simply accept it. The togetherness of the family unit should be fostered, not fought, by technology. Despite arguments to the contrary, the better-equipped, better-staffed facilities have the best perinatal morality and morbidity records.

Just as advocates of home deliveries cite their cause as an alternative to hospital deliveries, modern perinatology must be made a safe and satisfactory alternative to home deliveries.

Doctor Work is associate professor, Department of Obstetrics and Gynecology, University of Michigan Medical School. He is chairman of the 1978 Michigan Conference on Maternal and Perinatal Health.

Patient contracts a feature

How Escanaba program educates patients in their care

By Paul T. Werner, MD
Escanaba

Careful management of any patient care problem requires that the physician write a prescription for patient education. The wise physician understands the relationship between the patient's knowledge of his diagnosis and treatment plan and the success of that treatment. A systematic approach to patient education can assure greater yields in satisfied patients and increased therapeutic compliance.

Patient education can be defined as providing health information to bring about behavioral changes in the individual.

A thorough effort at patient education will serve multiple purposes. Perhaps foremost is a satisfied clientele. The patient who understands his problem is much more likely to comply with the treatment regimen, to return for follow-up visits, and to speak highly of the way his care is handled. Education can also prevent the broad chasms in doctor-patient relationships that frequently lead to litigation.

Finally, a program of education demonstrates a certain philosophy toward the care of a patient. This philosophy implies that it is the patient's responsibility to care for his own problem, aided by the doctor.

Patient education is a complex and superior medical skill, and the changing of behavior to improve patient care must be considered ethical if the patient is involved in the selection of needs and modalities.

Education should start at front door

Patient education "starts at the front door." The *systematic approach* demands that all care providers agree on the need for patient education. Staff education is often necessary to change the behavior of personnel toward patients on the subject of patient education. The entire staff must accept education as an important role that each provides: the staff members must "model" patient education. If the system is fully operational, the provision of patient education will be integrated so that certain pieces of information are reliably repeated to each patient. In addition, office education efforts should be coordinated with any available community education efforts for patients.

Fairly concrete objectives must be established for the entire patient education system and for individual components of it. The doctor and his staff are responsible for content objectives which address how deeply the individual practitioner and members of his staff wish to enter into patient education, what they hope the achieved behavioral changes and content acquired will actually be and how the evaluation of the program and its results will occur. The individual patient must help select the behavioral objectives, which seek to define changes in behavior with three parameters:

1. The behavior is specifically stated:
   "The patient will dip-stick his urine and compare the stick to the normogram."
2. The conditions under which the behavior will occur are specifically stated:
   "Urine testing will be done four times daily at home."
3. The criteria for success are specifically stated:
   "The urine test will be recorded in a diary to be brought to each office visit for check by the doctor."

Objectives should be flexible

Objectives should be flexible and simple for easy application. The objectives should "build in" planned reinforcement, such as rechecking the patient's diary. Well-written objectives should not keep health care providers from capitalizing on chance opportunities to teach the patient.

Objectives will serve the educational program well by:

1. Assuring grounds for communication among users, educators, and evaluators.
2. Locating the appropriate level of entry for any given patient — questions for pretesting can be selected on the basis of the objectives.
3. Pointing to the exact materials needed to foster the behavior specified.
4. Serving as a "measuring stick" to determine program success.
5. Allowing physicians to reinforce patient behavior because the

Doctor Werner

Doctor Werner is assistant professor, family practice, College of Human Medicine, Michigan State University, and medical director/preceptor, Upper Peninsula Medical Education Program, Michigan State University.

behaviors are specified in advance.

The patient education effort for any one patient or his family begins with identification of needs for information or behavioral changes. The level of current patient information must be assessed by asking, "How much do you already know?"

Doctor and patient must agree

The first and most important step requires that both the doctor and the patient agree that there is a need for increasing the amounts of information. When the need has been identified, goals must be set. Goals are simply defined as answers to the question, "Where do we want to be when we finally get there?" No two patients will have the same set of goals even with identical diagnoses. Thus, for each patient, a precise educationl prescription can be written. With goals properly selected and defined, methods of providing patient education can be easily selected and applied. The methods available range from simple handouts and discussion with the physician or nurse, to programmed textbooks, flipcharts, audio-visual presentations on video tapes and cassettes, slides, and filmstrips. An industry has developed in the United States to provide prepackaged materials for various common medical problems. The physician can use these materials to orchestrate an educational program. Yet setting goals and instituting behavioral changes constitute the core of the educational effort, and the actual materials which provide the information serve only as the vehicle for change. Methods must be adjusted to help each patient where he is: his educational level, his comprehension level, his attention span, and his personal handicaps all must be taken into consideration.

The optimal time to encourage changes in patient behavior is during the period of high motivation immediately following information input. The patient educator can help the patient to reason through the information he has just gained. A reasonable change in patient behavior might be planned.

Thorough evaluation is required to assure the items designed for patient care and the behavioral changes agreed upon have, in fact, made an impact on patient care. Thus, the physician must remember to reinforce the items learned and to inquire about the behavior changes. If full benefit has not been achieved, the whole process must be reinitiated by identifying new needs and setting new goals for additional education.

The concept is action

Program evaluation and feedback can help develop the system. One example of these concepts in action is a program currently operating in Michigan's Upper Peninsula. It is located at St. Francis Hospital, Escanaba, and was designed by faculty and students of the Upper Peninsula Medical Education Program of Michigan State University.

The program settled upon is a formal patient education program involving a specially trained educator, and serves the needs of a medical service area of some 30,000 to 35,000 patients. This program is available to any patient in this community upon prescription by the patient's physician. A full complement of programs is provided with materials derived from various sources.

The patient is given a pre-test to establish his level of knowledge; then a short discussion with the patient educator is held to establish general goals. A program is then viewed which involves the patient actively in learning by stopping and asking for immediate recall in the context of the program. A workbook is employed by the patient during the approximately 20-minute learning session. Following this session, the patient is given a short post-test. Then, the patient educator answers questions and assists the patient to establish objectives for behavioral changes.

These objectives are formalized in a written "contract," where the patient agrees to certain behavioral changes. A copy of this written contract is left with the patient educator, one goes with the patient, and a copy is provided for the doctor. Follow-up is provided by the patient educator who contacts the patient after a short period of time to see if the objectives are being met. Also, the physician can check the objectives in his office when he next sees the patient. A "Physicians Desk Reference" for patient education is in each doctor's office and at each nursing station in the hospital. This book describes the content objectives for over 100 separate programs. The most important component of the program is the direct one-on-one relationship with the patient educator who can adjust the goals and learning contract to meet the individual patient's needs. This patient educator can also select specific education materials.

This program is paid for by a small charge to the patient. Each patient is also given a short evaluation sheet to complete.

Physician the key

Clearly, above all, physician enthusiasm is the key ingredient to any program's success. Getting started is the hardest job. Although the patient education program in Escanaba is centrally located in the community to serve the entire area, a similar program can be established in any care setting, large or small. The basic model of a systematic approach to patient education applies even in a sole practitioner's setting. The patient educator might be a nurse, or the physician himself, or even a concerned housewife who is willing to learn enough about the programs which the physician uses regularly to serve in that role. Patients will respond positively when they discover information is being tailored precisely for their needs. The physician will benefit by improving the information his patient has, and through that improvement, making changes in the patient's behavior and attitudes that will assist in the care of the patient.

Sources of additional patient education materials and a bibliography are available from the author.

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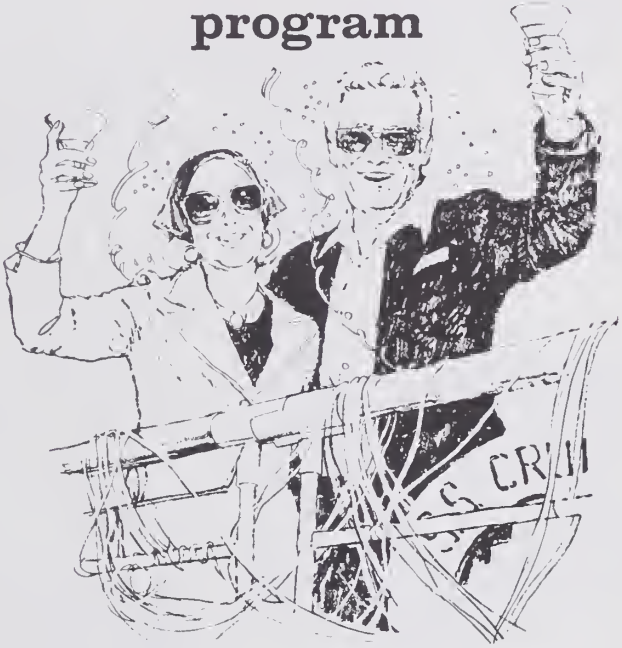

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Heartbeat

By Katie Brewbaker
MSMS Communication Staff

Dana Ellen Arvilla, MD, is first director of the new "Quality of Life Program" of the Michigan Health Council's Department of Rural and Community Health.

Henry Ford Hospital has named **Dietrick P. Blumer, MD,** chairman of the Department of Psychiatry, and **Joseph C. Cerny, MD,** chairman of the new Department of Urology. Doctor Blumer formerly was with McLean Hospital in Belmont, Mass. and associate professor of psychiatry at Harvard Medical School. Doctor Cerny formerly was chief of the Division of Urology at HFH.

Dan C. English, MD, is new chairman of the Department of Surgery at MSU's College of Human Medicine. Doctor English has been a faculty member of the MSU surgical department since 1971, serving as chief of the Division of General Surgery and director of undergraduate education.

Jose B. Gotay, MD, is recipient of the 1977 Environmental Quality Award presented by Region V of the U.S. Environmental Protection Agency. Doctor Gotay, commissioner of the Saginaw County Health Department, was cited for spearheading the development of the first comprehensive mosquito control program in Michigan.

The Detroit Lion's team physician, **Edwin Guise, MD,** recently addressed the American Orthopaedic Foot Society on the importance of accurate diagnosis and careful treatment of ankle injuries in football.

Thomas A. Helmrath, MD, is new associate dean for clinical services at MSU's College of Human Medicine. Doctor Helmrath, a pediatrician and associate professor of human development, recently received the prestigious Alfred P. Sloan Fellowship while earning a master of science in management degree at MIT.

MSU has named **William J. Klein, Jr, MD,** director of its Office of Health Services Programs. Doctor Klein formerly was chief of ambulatory services at Rochester General Hospital in New York.

Sol D. Packhard, MD, is the new president of the Michigan Heart Association. Doctor Packhard is associate professor of the Division of Cardiovascular Disease at Henry Ford Hospital.

Jan Schneider, MD, Ann Arbor, will become professor and chairman of the Department of Obstetrics and Gynecology at the Medical College of Pennsylvania, effective Jan. 1. Doctor Schneider has been professor of Ob-Gyn and maternal and child health at the University of Michigan.

Richard C. Schneider, MD, head of the Neurosurgical Section at the University of Michigan Hospital, has produced an award-winning film on "First Aid for Head and Neck Injuries in Football." The film has received the American Medical Writers Association's Award for Special Merit and the Silver Screen Award at the U.S. Industrial Film Festival. In addition, it was awarded Honorable Mention at the American Film Festival. The film is available from the Film Production Unit at the U-M Audio-Visual Education Center, 416 South 4th Street, Ann Arbor 48109.

The new president of the Michigan Society of Therapeutic Radiologists is **J. Clyde Spencer, MD,** of Lansing's Sparrow Hospital. **Carla A. Cook, MD,** with Henry Ford Hospital, serves as Chairman of the Board.

Special tribute has been given to **Frank VanSchoick, MD,** of Jackson by his hometown newspaper for his 50 years of dedication to public health. In a lengthy feature article, the *Citizen Patriot* enumerated Doctor VanSchoick's outstanding contributions in the advancement of infant care and immunology.

Doctor Arvilla

Doctor Gotay

Doctor Guise

Doctor Helmrath

Jan Schneider

Physicians should shop around before buying that computer

By Judith A. Johnstone
Special to Michigan Medicine

"'Computer ignorance' has led to overexpectation and consequent disappointment and failure." Thomas T. Chen — assistant professor of computer science and assistant director of medical information science at University of Illinois — at a National Computer Conference.

In these days of skyrocketing costs, it may be wise to re-examine the methods and the costs associated with billing our patients. As billing gives us our prime income, any efficiencies gained by an evaluation can only increase profits.

As you evaluate, you should consider the four main methods of billing. These methods can handle private, Blue Shield, Medicaid, Medicare, and "other insurance" bills. They are (1) manual, (2) billing machine, (3) service bureau, and (4) private computer methods.

Manual and billing machine methods are quite sufficient for a practice with a limited number of patients and may indeed be the most cost-effective. However, once an individual reaches peak efficiency, only a specific number of bills can be produced. When that limit is reached, the only way to exceed that number is with additional personnel which decreases the cost-effectiveness.

If you find yourself at that limit, it may be wise to begin searching for alternative solutions.

Alternative #1 — the service bureau

A service bureau is an organization which has either its own computer or access to a computer. Depending upon the level of sophistication and the services you desire, the service bureau might offer any service from producing bills to complete financial management. To determine which service bureau you desire, you might ask about:

- Security

Will your records be in a separate file or grouped together with records from other practices? Generally a separate file system is preferable because your records will be processed by themselves, not with others which can lead to errors in processing.

What prevents unauthorized access to your files? A "password" system is desirable, thereby preventing illegal updating of your files.

- Services Offered.

To what extent will the service bureau tailor its system to exactly meet your needs? Perhaps no tailoring is required to produce a bill fitting your specifications.

What other services may be rendered? Does the bureau provide data on aging of accounts and bad-debt writeoff? You may already have a financial manager, and some of the offered services may overlap. Perhaps quoted prices may be reduced if some items are not desired.

- Cost.

What does the quoted cost include? Obviously postage, forms, and processing should be included, but does it also include all other reports you may desire? How much processing will be done by the service bureau, and how much by your personnel? It may be more cost-effective to have your people prepare the data before handing it over to the service bureau.

- Data Availability.

If your practice is one in which patients call to inquire about their accounts, you must have access to this information, either through the service bureau or your own records.

Alternative #2 — the private or "in-house" computer

An in-house computer is one which is leased or purchased by you. You are responsible for providing personnel to operate the system and personnel to enter the data into the system. You must also provide appropriate environmental conditions and power supplies for any computer you might select.

Before you shop — know your practice!

How many patients do you serve? What is the expected growth rate? What data do you maintain on each patient? What do you expect from a computer system — patient billing (accounts receivable), payroll, patient record-keeping, accounts payable?

How much do you currently spend on the above items?

Shop!

Ms. Johnstone is business manager of Ingham Radiology Associates, PC, Lansing. She has worked 12 years in the data processing field as a systems analyst and project manager. She has been employed with manufacturing, consulting and computer vending firms.

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1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

Intravenous administration should not be given because of increased likelihood of side effects.

Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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By Katie Brewbaker
MSMS communications staff

Two important state society projects have moved ahead in recent weeks. One is the new building at MSMS headquarters, recommended by the Ways and Means Committee after extensive feasibility and architectural studies. Construction on the building is scheduled to begin yet this year. The second project is the selection of an investment counselor for MSMS funds. After review of MSMS fund management principles, the Ways and Means Committee recommended a counselor be chosen by the MSMS board of managers. Participating in the planning of the two new projects were, from left, Louis E. Heideman, MD, MSMS president-elect; Richard J. McMurray, MD, Ways and Means Committee member; John R. Ylvisaker, MD, MSMS treasurer; Robert E. Paxton, MD, chairman, MSMS Ways and Means Committee, and back to camera, David Siegel, MD, vice chairman, MSMS Council.

Intoxication no longer a crime

Beginning Jan. 15, the Substance Abuse Assistance Act (PA 339, 1974) will become law. Act 339 provides that incapacitated persons be taken to hospitals or detoxification centers rather than to jail.

Excluded from the law are persons who have committed a felony while incapacitated. Also, a police officer has the option of determining whether an incapacitated person who has been placed under custody for a low misdemeanor should be taken to a treatment center or incarcerated.

The MSMS Committee on Alcohol and Drug Dependency thoroughly studied Act 339. It met with representatives of the Governor's Office, Michigan State Police, Prosecuting Attorneys Association, Office of Substance Abuse Services, American College of Emergency Physicians, and the Michigan Hospital Association to discuss the smooth implementation of the law.

A comprehensive article on Act 339 is being prepared by Richard C. Bates, MD, chairman, MSMS Alcohol and Drug Dependency Committee, for publication in a future issue of *Michigan Medicine.*

MSMS committee strongly supports immunizations

The MSMS Council has adopted a recommendation of the **Committee on Public and Environmental Health** calling for MSMS to "support the efforts of the Michigan Department of Public Health to enforce the School Health Code requirements that all children at the point of entry into school be immunized against specific disease."

Many school systems are not complying with the requirement that students must present evidence of immunization against measles, rubella, diphtheria, tetanus, whooping cough, and polio when they enter school. (Students who can present a statement of religious objections are exempt from the Code). Failure to comply with the law has proven to be an increasing problem, particularly in schools with large enrollments where crowded conditions make the children especially vulnerable to epidemics.

The MSMS Division of Government Relations and Division of Public Service, Communications, and Physician Education will be available to advise the Michigan Department of Public Health in the campaign for compliance with the School Health Code.

New maternal health desk reference cards set

Two new Desk Reference Cards are being developed by the **Committee on Maternal and Perinatal Health**; card No. 23 on "Neonatal Hyperbilirubinemia" and No. 24 on "Contraceptives and Family Planning." In addition, the card on "Spinal Anesthesia (Saddle Block) in Obstetrics" is being revised. These cards will be published, as special tear-outs, in future issues of *Michigan Medicine.*

In Memoriam

Harold H. Gay, MD
Coleman

Harold H. Gay, MD, Coleman, died Sept. 1 at the age of 77. A graduate of University of Michigan Medical School, Doctor Gay served as medical director at Dow Chemical Company. A former chairman of the Michigan State Board of Alcoholism, he also was a former president of the Michigan Industrial Medical Association and the Midland County Medical Society.

Selma Kansa, MD

Selma Kansa, MD, died Sept. 2 at the age of 59. Doctor Kansa graduated from Tartu Ulikool University, Estonia.

Traian Leuctuia, MD
Detroit

Traian Leuctuia, MD, 85, Detroit, died Sept. 12. A native of Romania, Doctor Leuctuia graduated from the University of Budapest. He earned an international reputation for pioneering protective devices against electrical and radiation hazards of X-rays. Doctor Leuctuia was editor of the distinguished *American Journal of Roentgenology, Radium Therapy and Nuclear Medicine.* He also received a gold medal award from the American College of Radiology.

W. A. Schmutzler, MD
Kingsford

W. A. Schmutzler, MD, Kingsford, died Aug. 9 at the age of 56. Doctor Schmutzler was a graduate of University of Cincinnati College of Medicine in Ohio. He was a past president of Dickinson-Iron County Medical Society.

Milton Shaw, MD
East Lansing

Milton Shaw, MD, East Lansing, died Sept. 19 at the age of 88. A graduate of the University of Michigan Medical School, Doctor Shaw was city physician in Lansing after serving in World War I and then was in private practice for nearly 60 years. He was a member of the American College of Physicians, past president and historian of the Ingham County Medical Society, trustee of the Michigan Heart Association and a member of the American Red Cross.

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RADIOLOGIST part or full time, board eligible or certified for salaried position with Clinic Group in Detroit Metropolitan area. Nuclear Medicine and planned ultra sound. Good benefits and liberal salary. Call or write Trail Clinic, P.C., Cindy Papuga, Clinic Secretary. (313) 861-4400, 18254 Livernois, Detroit, MI 48221.

PSYCHIATRIST — Suburban Detroit area hospital has a full-time staff vacancy for a psychiatrist to assume the responsibilities of Director of Outpatient Mental Health Services. Excellent salary range, hospital paid benefit program and regular hours. Interested physicians should submit their curriculum vitae in confidence to: Wesley E. Kokko, Director of Personnel Services, Wyandotte General Hospital, 2333 Biddle Avenue, Wyandotte, MI, 48192, 313/284-2400 ext. 2611.

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Direct inquiries to: SEARCH COMMITTEE, Southwestern Michigan Rehabilitation Center, Inc., 183 West Street, Battle Creek, MI 49017. Tel: 616/965-6315.

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Potpourri

By Herbert A. Auer, Executive Editor

In a Louis Harris organization survey of 600 families, 85% said they realize the importance of regular exercise — but only 32% had any regular exercise program.

* * *

Lawrence J. Peter writes in *Peter Principle* that, "A man with a new idea is a crank, until the idea succeeds."

* * *

HEW reports that the number of Medicaid recipients is up from 13 million in 1976. Let's insist that lawmakers, editors, all others include those figures too when they point to the larger amounts of money being paid by government to doctors for Medicaid care.

* * *

"Physicians can no longer afford to sit back and unconcernedly watch a colleague drink himself into trouble or cover up for him if he's incompetent," writes *Wisconsin Medical Journal* editor W. J. Boulanger. Doctor Boulanger urges doctors "to put into action" the mechanisms to help the impaired physician.

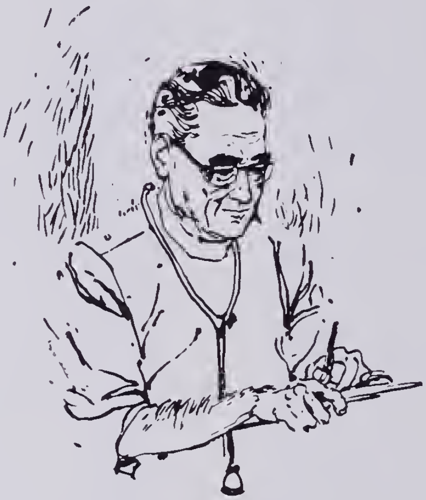
* * *

In 1936, the *Federal Register,* which publishes all new government regulations, ran a total of 2,411 pages. By 1970, it reached 20,000 pages. Today it is well over 60,000 pages.

* * *

Otis G. Bowen, MD, governor of Indiana, said, "You can't be involved if you don't care, or your involvement is unnecessary and probably harmful. Care, and contribute some of your time, talent, effort and finances." That is one of his AMPAC appeals.

* * *



William S. Reveno, MD, Detroit, beloved Detroit physician and respected author of "Medical Maxims" which appear in each issue of the *Detroit Medical News,* makes many observations in his book, *Medical Maxims III,* including these:

> "The expert is rarely in doubt yet often in error.
>
> "Time is the superb wonder drug.
>
> "Medicine achieves public approval more by finding and solving the previously unsolved, more difficult problems than by simplifying and reducing costs of established processes.
>
> "Pill Power versus Will Power — a constant conflict for both patient and doctor."

* * *

Tell your neighbor when he belittles the accomplishments of the medical profession that polio vaccine eliminated iron lungs, lengthy hospital stays and saved thousands of potential victims.

* * *

"Organized medicine is a vested interest and we should be proud of it," declared James S. Todd, MD, of New Jersey, at the 1977 AMA Leadership Conference. He continued, "Proud because a vested interest is defined as one in which the holder has a strong personal commitment."

* * *

We can all change dry cleaners or butchers when dissatisfied, but have you ever gone to the post office to demand your 13 cents back because it took them six days to deliver a letter 20 miles?

* * *

Author C. P. Snow was asked at a Northwestern University lecture to "compare the state of man's mind today to what it was at the turn of the century?" He observed that "man today is a good deal less secure than he was even in 1900. He is much more humble and probably, with good fortune he may achieve a more sober and sensible view of what the human condition is."

* * *

The members of the Michigan Academy of Family Physicians heard B. T. Meade, MD, Omaha psychiatrist, say at the summer meeting, "most doctors don't love themselves enough." He continued, "Doctors must learn to accept success and stop worrying about a few failures. Doctors focus on the needs of others but seldom do they know their own emotional needs."

* * *

Did you know that . . . 25 to 50 percent of all published scientific papers are not cited by another author — ever.

Michigan Medicine Contents

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to provide useful information for Michigan physicians about contemporary issues and actions of the Michigan State Medical Society, with special emphasis on socio-economics, legislation and news about medicine in Michigan. Major medical developments will be reported and interpreted as has been the custom.

MSMS headquarters

Special articles

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In the next issue . . .

Special section on CME in Michigan

President's Page

Blues are disenfranchising our patients

I can't participate with Blue Cross/Blue Shield of Michigan. To do so would strike a blow against my patients. I feel the Blues no longer believe patients have the right to select their own physicians.

The patients have no champion or guardian to protect their interests. We — their physicians — must do so for our individual patients. We collectively as MSMS must fight to protect the citizens of Michigan and their rights.

Patients have the right to choose their own physician regardless of which insurance company the physician participates with, or whether he or she participates at all.

These are the things we are fighting for. We believe we are in the right.

Not only do the Blues' new programs — vision care, hearing care and overall reimbursement policies — discriminate against me if I choose not to participate; the Blues also are telling my patients they won't get the insurance protection they have paid for if I choose not to participate with the Blues.

In essence, that makes it impossible for the patient to choose an MD who does not participate with the Blues.

The Blues' new programs also cause inconvenience. And they disregard the emotional factor. People want their own doctor, the physician they have faith in, whether par or non-par MD.

We all know the importance of the patient's faith in his healer. That's what we mean when we talk about the doctor-patient relationship. That's what we see being destroyed by plans such as the Blues' so-called cost-containment efforts.

The major concern is that these Blues programs are not cost containment — they do exactly the opposite. Those involved with the vision and hearing programs say they are very costly.

We physicians are being bribed by the Blues — if we are good and hold down utilization, they tell us, we get to keep half the savings. Where do they get that money from in the first place? From our patients and their employers.

All this is particularly galling when the Blues did not consult us in any way before drawing up these new plans to offer our services.

My patients get confused and angry when I tell them that if I choose not to participate with the Blues, they cannot come to me anymore without having real problems in paying for my services, even though my fees remain the same and even though they have already paid the Blues to help meet their medical costs.

They should be angry, for they are being disenfranchised. And this is the message we should tell all Michigan citizens.

Vernon V. Bass, MD
MSMS President

What is the significance of the Blues situation to concerned MSMS members? See pages 610-611.

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*R. B. Greenblatt, M.D.; R. Witherington, M.D.,; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and Female Climacteric. **Drug Therapy**, Sept. 1976.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg., Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg., Postpuberal cryptorchism, 30 mg **REFERENCE: Robert B. Greenblatt, M.D.**, and **D. H. Perez, M.D.:** "The Menopausal Syndrome." *Problems of Libido in the Elderly*, pp. 95-101 Medcom Press, N.Y., 1974 **HOW SUPPLIED**: 5, 10, 25 mg in bottles of 60, 250. Rx only.

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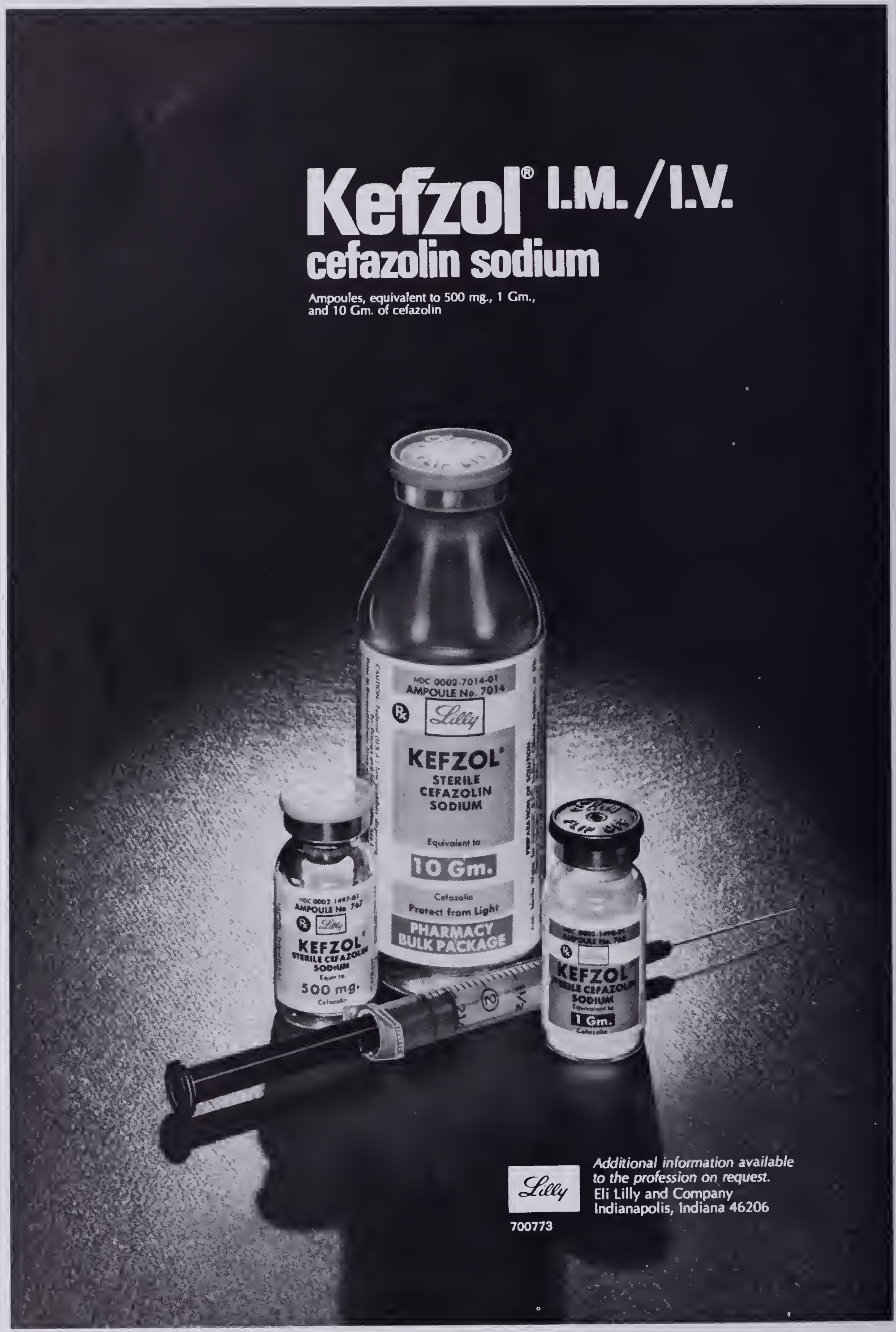

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MSMS Report

Local peer review systems under review by components

Michigan component medical societies are reviewing the operations of their peer review committees at the recommendation of MSMS.

The review was urged this fall by MSMS legal counsel to make certain that no component societies would be in violation of anti-trust laws through their fee review activities.

"MSMS had no evidence of intent by such committees to engage in the setting of fee schedules," said MSMS Council Chairman Ernest P. Griffin, Jr., MD, in a letter to component societies, but "it is apparent in the current anti-trust climate that charges could be made that the opportunity exists and/or that third party payors may have so utilized county committees."

The MSMS Council in July approved an MSMS ad hoc committee's four recommendations to alter the operation of county society peer review activity.

"These changes were necessitated by the possibility that some county committees were reviewing fees for particular procedures for third party payors with sufficient continuity to passively permit the payors to adopt those adjudications for future fee scales as to those procedures."

The four recommendations for change, which were also accompanied by operational guidelines, called for (1) the discontinuation of the MSMS Committee on Utilization and Health Insurance Problems, as it is no longer needed under the new system; (2) for designating county society mediation committees as the proper bodies to mediate (not arbitrate) fee disputes after the fact, and (3) for an MSMS bylaws change which defines the purpose of the county society peer review committees: to respond to requests from patients and third parties concerning fee disputes. It shall not be the purpose of such committees to establish fees, but to resolve disputes. Each case shall be considered on its own merits. It shall not be the intent of such committees to establish precedents.

MSMS 'Medilabels' now state project

Michigan motorists now may state on their drivers' licenses if they have any special medical problems or if they wish to donate any organs for medical research.

The new policy, which became effective in mid-August, is a continuation of the "medi-label" project originated in the 1960s by MSMS. Labels now can be filled out and affixed to the back of drivers' licenses to assist emergency personnel at the scene of accidents. The labels are being distributed by the Secretary of State's office.

The former MSMS Highway Injury Committee distributed labels through physicians' offices in the 1960s. In 1973, the medi-label project was reactivated as a joint effort of MSMS, the Michigan Association of Osteopathic Physicians and Surgeons, the Michigan Department of Public Health and the Secretary of State's office.

At that time, 110,000 labels were ordered by Michigan physicians for response to promotion by the Secretary of State's office.

MSMS delegates vote unanimously for departicipation

The vote was unanimous when 250 MSMS delegates and alternates called for departicipation with Blue Cross/Blue Shield of Michigan in protest of the Blues' new programs. The delegates met in special session Oct. 26 at the Troy Hilton.

The delegates were animated in private discussions, and gave a standing ovation to recommendations for departicipation and lawsuits. A dues increase also was approved. At right the Genesee delegation, from left, Glenn E. Moore, MD; Robert J. Rathburn, MD; Franklin V. Wade, MD; James J. Gibbons, MD; John C. Benson, MD; Charles A. Thompson, MD.

Clarifying a point for the MSMS delegates is Louis F. Hayes, MD, alternate from Wayne, and Blues' vice president for provider relations.

Please turn the page for key Michigan physicians' views of the significance of the Blues situation.

The reference committee discussing resolutions involving legal activities was aided by MSMS Legal Counsel A. Stewart Kerr, standing left, and was led by Donald N. Sweeny Jr., MD, standing center.

Below: key person in the special House meeting and in MSMS activities involving the Blues is Donald K. Crandall, MD, Muskegon, left, chairman, MSMS Negotiations Committee. Facing the camera is George M. Wilson, Jr., MD, Marquette.

James D. Fryfogle, MD, right, speaker of the MSMS House, confers above with Delegate Marvin L. Starman, MD, Southfield. Doctor Fryfogle told the delegates he had seldom seen such fervor on an issue.

Doctor Grigg

Doctor Hessburg

Doctor Johnson

What they think about th

• *John W. Grigg, MD*
Bay City

Many otolaryngologists are presently participating physicians in Blue Cross/Blue Shield as a matter of their individual choice. When someone says you have to participate, that is an interference with the patients' freedom of choice in choosing a physician.

"Why should I have to participate if I don't want to? This should be a matter between my patients and me alone. Why should the patients be penalized because they desire services by a non-par doctor? Why shouldn't reimbursement be made directly to the patient rather than not at all?

"On the other hand, I believe doctors themselves have been remiss in fee adjudication, partly because third party carriers have been secretive about profiles. Doctors have been reluctant to discuss fees for fear of possible anti-trust violation. I see no reason why professionals cannot discuss fees and set reasonable charges.

"I see a far greater danger than forced participation in the hearing aid program. I envision that the next step will be that we will be told, 'Either participate or no one is going to be paid for any services.' This will have some grave connotations for patients and physicians alike.

Doctor Grigg is an otolaryngologist and former chairman of the MSMS Judicial Commission.

• *Philip Hessburg, MD*
Grosse Pointe Park

"The motors have made it very clear — they want par vs. non-par. They have said several times they do not want a war with physicians. Apparently we should submit docilely to show our easy affability to this type of health care planning. The motors are willing to sacrifice the freedom of their employees for an alleged cost saving.

"I am now certain the motor companies wish to extend principles of these new programs over all areas of medicine. That eventually will allow the UAW — Blues — motor company — health care planners to control all areas of health care — quality — quantity — availability — cost, not only in Michigan but elsewhere in the U.S.

"As I see industry, in a legitimate effort to contain costs, interfere with the freedom of choice of their employees, establish reimbursement policies for other providers in negotiations to which those persons are not invited, and agree to fix the prices of a product they provide their employees, I wonder what the response might be if the tables were turned; in each instance, a similar situation can be envisioned in which the aggrieved party would be the U.S. auto maker."

Doctor Hessburg is a member of the Prepaid Eye Care Committee of the Medical Eye Services of Michigan corporation.

• *Kenneth H. Johnson, MD*
Lansing

"In my opinion, there is only one way to effectively counter this tactic (of the Blues: penalizing the nonparticipating physician so he will be forced to participate). That is to resign from participation, with the hope that faced with what might be very serious consequences, Blue Shield/Blue Cross will have the guts to stand up for the original principle of service to the public at large, and if necessary tell some people with less than this in mind, to 'go to Hell.'

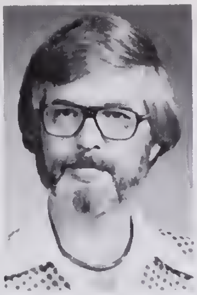
"It is with a deep feeling of regret that I have resigned as a participating physician effective Jan. 1, 1978. I have done so in keeping with the action of the MSMS House of Delegates because I believe that only by a uniformly-concerted action by each and all physicians will we get a message across to the management of Blue Shield, the hierarchy of the UAW and the management of the autos.

"The original concept of Blue Shield as an insurance program, as thought out by the leaders in organized medicine at that time, was the protection the plan offered the low income members of the public from catastrophic illness. This concept is not dead and it is my sincere hope that Blue Cross/Blue Shield will survive the crises that now surround them and come out more secure than before."

Doctor Johnson is MSMS Secretary.

Doctor Luby

Doctor Sentkeresty



Doctor Turcke

Blues situation

• *Elliot D. Luby, MD*
Southfield

"The Blues are a beseiged organization. They are increasingly under the control of consumers. In order to survive, they are doing whatever they can to contain costs. In the process of doing this they simply are not listening to physicians any longer. They are developing an adversary relationship with us which will result in further deterioration of our relationship with them.

"I know in psychiatry they have not listened to us for some time, when we could have significantly reduced their expenses, particularly with regards to outpatient psychiatric clinics. They totally ignored our advice and now are paying out 10 to 15 times their premium.

"Many of these problems will be tested in the courts which may be the only way in which we can gain relief. We should still strive to maintain a strong relationship with the Blues, but if they shut us out, there is nothing we can do."

Doctor Luby is president of the Michigan Psychiatric Society.

•*Joseph A. Sentkeresty, MD*
Grand Rapids

"The most important thing to remember is that a contract should only exist between the physician and the patient for services rendered and payment due. Whether or not a third party pays a portion or all of the fee is another matter, as this represents another contract that exists between the patient and his insurer only and doesn't enter into the issue. We should continue to deal with the patient on a one-to-one basis regardless of who the third party is.

"The problem will be the Blues will discriminate against the patients — their subscribers — by dictating which physicians they see. The benefits will vary. Blues can pay one subscriber less than another, while the subscribers or their employers will pay the same premiums. This clearly is unconstitutional, illegal and indiscriminate. It should not exist. The Blues should have to pay the same benefit.

"I would hope we carry the battle and do not drop the ball here. The worst thing we could do is to let it all slide. If we stop and back down now we will look foolish and once again be divided and conquered. Likewise, our patients will also be losers."

Doctor Sentkeresty is immediate past president, Michigan Society of Internal Medicine.

• *Allen F. Turcke, MD*
Flint

"I think it's a very unfortunate situation that matters have to come to an impasse before we can achieve any satisfactory mutual goals. I think the medical profession, insurance companies, unions, motors and other important factors in this situation should quit being anti and join together to work toward constructive goals which would help others.

"This may be the best thing that ever happened because programs such as Medicare and Medicaid and other first dollar coverage plans have really made life easier for most doctors. Now it's time to get back to basics, to the premise that it's a doctor-patient relationship, period. That also includes fees. A doctor offers the patient a service for X dollars. It shouldn't matter if the patient is getting reimbursed by any third party company or other source.

"I've always been non-par for that reason. I make my patient responsible to me for the fee.

"I think we have to make each doctor willing now to bite the bullet. If a doctor switches to non-par status his income will be reduced for several months. But that shouldn't be too hard to take. The doctor has to be willing to live on a reduced income for a short time.

"I think we have to wait and see what happens with this situation. But somehow we have to get to the point that everyone is willing to say they all are interested in cost control and will get together and talk about it.

"But the patient has to be responsible and somehow be educated that his self-pollution is the major cause of high medical care costs."

Doctor Turcke is president, Genesee County Medical Society.

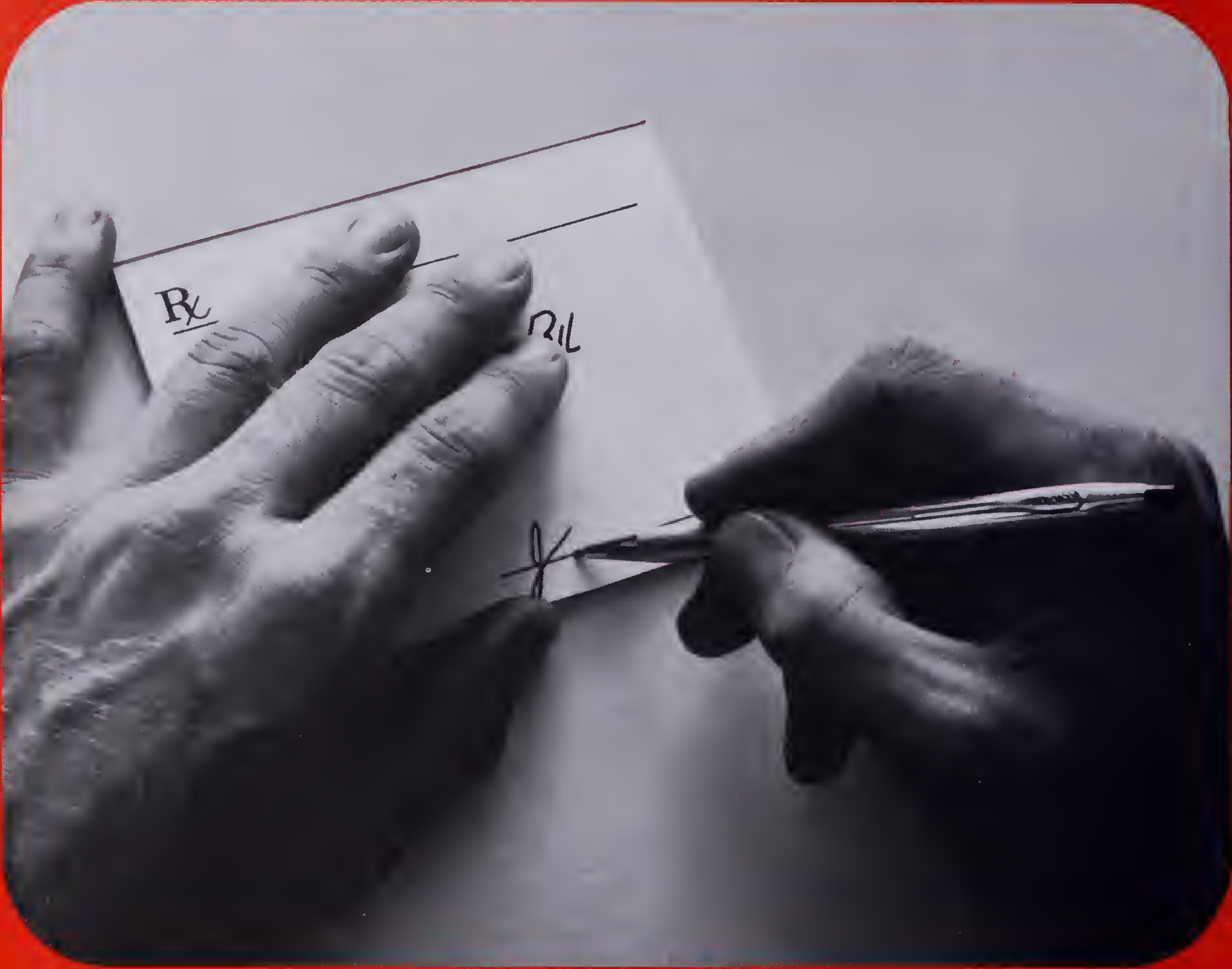
• *Charles R. Zimont, MD*
Constantine

"I feel the Blues are taking away some of the patients' rights to pick their doctors. They are legislating who can see whom.

"I'm in support of the MSMS delegates. I believe physicians should be non-par if they aren't now, and if they are, go ahead and write the Blues that they intend to stay that way. I have. Our lawyers have shown us various ways to approach the situation and I think we should use their advice to deal with this misuse by third party carriers. And I believe we not only have to tell the Blues we're upset and concerned enough that we're going to unload on them, but have explanatory information available in our offices so people can pick it up. Public awareness is the main factor now."

Doctor Zimont is president, Michigan Academy of Family Physicians.

There is no substitute



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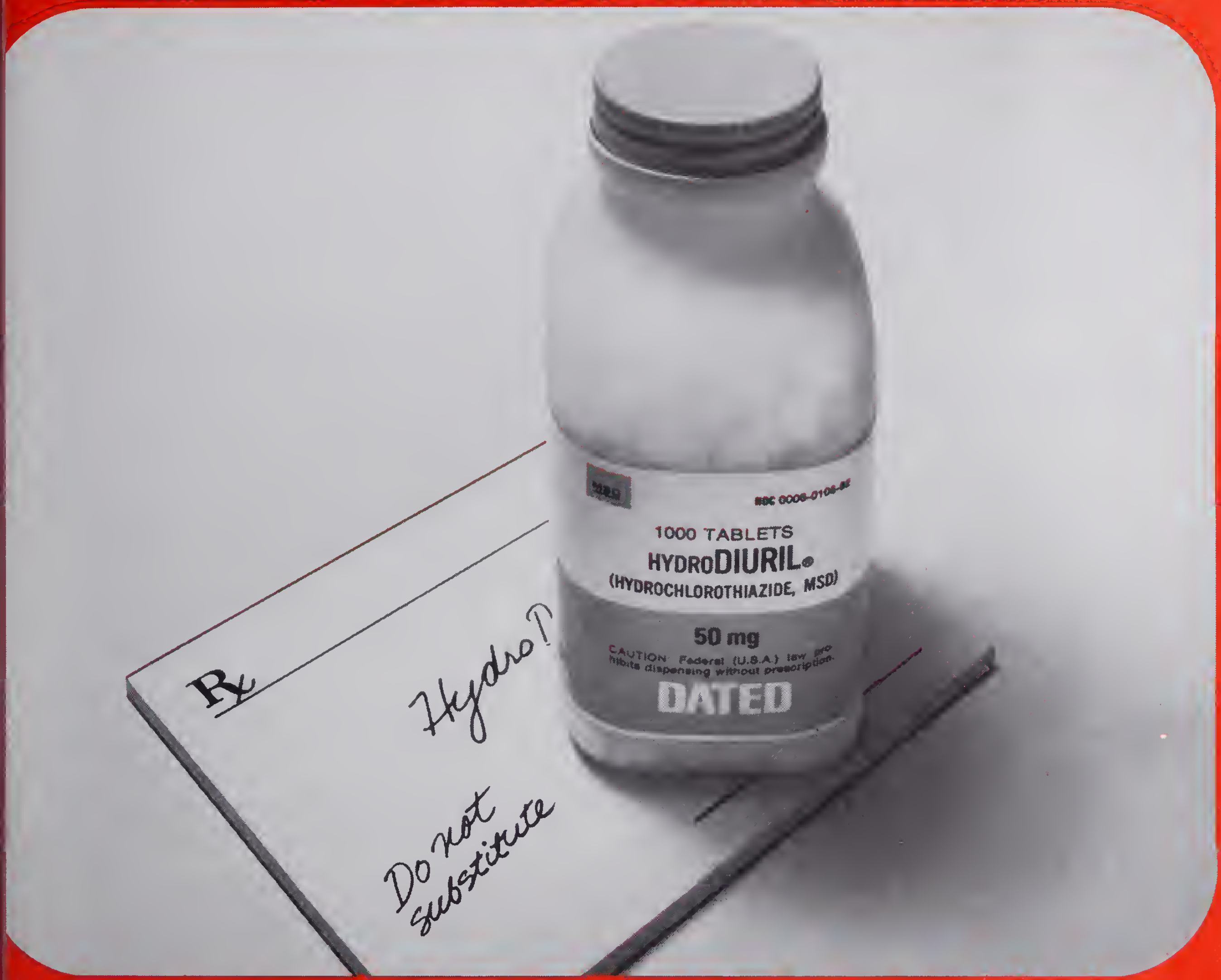
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Category I Courses

Michigan Medicine *each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, 517/337-1351*

The following have been accredited directly by the AMA or by MSMS Commission on Continuing Medical Education:

Organizations:

American Association for Hand Surgery, Warren
American College of Emergency Physicians, Lansing
American College of Psychiatrists, Southfield
American Society of Colon and Rectal Surgeons, Detroit
Ann Arbor Psychiatric Association
Commission Professional and Hospital Activities, Ann Arbor
Michigan Academy of Family Physicians
Michigan Academy of Plastic Surgery
Michigan State Medical Society
Michigan State University College of Human Medicine, East Lansing
Michigan Chapter, American Academy of Pediatricians, Detroit
Michigan Chapter, American Academy of Pediatrics
Michigan Dermatological Society
Michigan Heart Association
Michigan Lung Association, Lansing
Michigan Society of Anesthesiologists
Noah Worcester Dermatological Society, Detroit
Section on Gastroenterology, American Society for Gastroenterology, Detroit
University of Michigan Medical Center, Ann Arbor
University of Michigan School of Public Health
Wayne State University School of Medicine, Detroit

Hospitals:

Alma-Gratiot Community Hospitals, Alma
William Beaumont Hospital, Royal Oak
Beyer Memorial Hospital, Ypsilanti
Blodgett Memorial Hospital, Grand Rapids
Bon Secours Hospital, Grosse Pointe
Burns Clinic Med. Center, PC/Little Traverse Hospital, Petoskey
Butterworth Hospital, Grand Rapids
Central Michigan Community Hospital, Mt. Pleasant
Chippewa County War Memorial Hospital, Sault Ste. Marie
Community Health Center of Branch County, Coldwater
Community Hospital Association of Battle Creek
Cottage Hospital of Grosse Pointe
Detroit-Macomb Hospital Association
Ferguson-Droste-Ferguson Hospita Grand Rapids
Grace Hospital, Detroit
Hawthorn Center, Northville
Henry Ford Hospital, Detroit
Holy Cross Hospital, Detroit
Hurley Medical Center, Flint
Ingham Medical Center, Lansing
Kalamazoo State Hospital
Lakeshore Continuing Medical Education, Inc. (Hackley Hospital and Mercy Hospital), Muskegon
Marquette General Hospital
McLaren General Hospital, Flint
Mercy Hospital, Port Huron
Mt. Carmel Mercy Hospital & Med. Center, Detroit
Munson Medical Center, Traverse City
North Detroit General Hospital, Detroit
Oakland Medical Center, Pontiac
Oakwood Hospital, Dearborn
Pontiac General Hospital, Pontiac
Port Huron Hospital CME Committee
Providence Hospital, Saginaw
Saginaw Cooperative Hospitals, Inc., Saginaw
Southwestern Michigan Area Health Education Center (Bronson Hospital and Borgess Hospital), Kalamazoo
St. Francis Hospital, Escanaba
St. John Hospital, Detroit
St. Joseph Hospital, Flint
St. Joseph Mercy Hospital, Pontiac
St. Joseph Mercy Hospital, Ann Arbor
St. Lawrence Hospital, Lansing
St. Mary's Hospital, Grand Rapids
St. Mary Hospital, Livonia
Sinai Hospital of Detroit, Detroit
Edward Sparrow Hospital, Lansing
Traverse City State Hospital, Traverse City
V. A. Hospital, Battle Creek
Wayne County Psychiatric Hospital, Eloise
West Shore Hospital, Manistee
Ypsilanti State Hospital, Ypsilanti

Date: Jan. 4, 11, 18, 25; Feb. 1 & 8, 1978, **Forensic Psychiatry for the Non-Forensic Psychiatrist. Location:** Fisher Auditorium, Providence Hospital, Southfield. **Sponsor:** Providence Hospital. **Co-Sponsor:** The Michigan Psychiatric Society Rotating Lecture Series. **For:** Psychiatrists. **Cost:** $25. **Contact:** 313/493-6212. **Approved for:** 9 hours of Category I Credit.

Date: Jan. 18, **Meadow Brook Lecture Series in Medicine and Surgery, "Disordered Lipid Metabolism — The Mechanics and Treatment." Location:** Meadow Brook Hall, Rochester. **Sponsor:** Oakland Health Education Program. **For:** All specialties. **Cost:** $75 for whole series (four lectures), $20 each individual lecture. **Contact:** Gail Anne Rassier, Administrative Secretary, Oakland Health Education Program, 268 South Foundation Hall, P.O. Box 84, Rochester 48063, 313/377-4360. **Approved for:** 2 hours of Category I Credit.

Date: Jan. 20, **"Aerobics and Preventive Medicine." Location:** Longs Convention Center, Lansing. **Sponsor:** Central District Dental Society. **Co-Sponsor:** Ingham Medical Center. **For:** All specialties. **Contact:** M. H. DeLuca, DDS, M. S. Nasif, DDS, Program Chairman, 3320 W. Saginaw, Lansing 48917, (517) 321-4254. **Approved for:** 6 hours of Category I Credit.

Date: Feb. 5-10, **Michigan-Indiana Family Practice Update. Location:** Boyne Highlands. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-Sponsor:** Michigan Academy of Family Physicians-Indiana Academy of Family Physicians. **Cost:** $175 for physicians, $90 for physicians-in-training. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education*. Approved for 21½ hours of Category I Credit.

Date: Feb. 10-11, **Topics in Adult Psychiatry. Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education*. **Approved for:** 11¼ hours of Category I Credit.

Date: Feb. 14, **Sexually Transmitted Diseases. Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education*. **Approved for:** 7 hours of Category I Credit.

Date: Feb. 20-24, **Emergency Medicine. Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-sponsor:** American College of Emergency Physicians. **Cost:** $225 for physicians, $125 for physicians-in-training. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education*. **Approved for:** 36¼ hours of Category I Credit.

Date: Feb. 28, **Continuing Pathology Conference. Location:** Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $20. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education*. **Approved for:** 6½ hours of Category I Credit.

Date: March 1, **Cooperative Chemotherapy Review. Location:** School of Medicine. **Sponsor:** WSU School of Medicine. **For:** All interested physicians. **Contact:** Wayne State University, Division of CME, WSU School of

Medicine, 1206 Scott Hall, 540 E. Canfield, Detroit 48201, 313/577-1180. **Approved for:** 3 hours of Category I Credit.

Date: March 8-10, Hemotology Review. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education*. **Approved for:** 21 hours of Category I Credit.

Date: March 15, Meadow Brook Lecture Series in Medicine and Surgery, "Anaerobic Infections." Location: Meadow Brook Hall, Rochester. **Sponsor:** Oakland Health Education Program. **For:** All specialties. **Cost:** $75 for series, $20 each lecture. **Contact:** Gail Anne Rassier, Administrative Secretary, Oakland Health Education Program, 268 South Foundation Hall, P.O. Box 84, Rochester 48063. **Approved for:** 2 hours of Category I Credit.

Date: March 16-17, Newer Concepts in Gastrointestinal Surgery. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $130. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education*. **Approved for:** 14 hours of Category I Credit.

Date: March 22-23, Advances in Pediatrics. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $120. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 14 hours of Category I Credit.

Date: March 30-31, The Spine and Spinal Cord. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education*. **Approved for:** 14 hours of Category I Credit.

Date: April 6-7, Ophthalmology Conference. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education*. **Cost:** $140. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 14 hours of Category I Credit.

Date: April 12-13, Symposium on Child Development. Location: Western Michigan University, Kalamazoo. **Sponsor:** Southwestern Michigan Perinatal Association. **Co-sponsor:** SMAHEC. **For:** Pediatricians, family practitioners, obstetricians. **Contact:** Valerie Lincoln, RN, Perinatal Coordinator, Bronson Hospital, 252 E. Lovell, Kalamazoo, 49007.

Date: April 14-15, The Wayne State University School of Medicine 11th Annual Cancer Symposium, "Cancer of the Colon and Rectum." Location: Gordon H. Scott Hall, 540 E. Canfield, Wayne State University, School of Medicine, Detroit 48201. **Sponsor:** Wayne State University. **Co-sponsor:** American Cancer Society, Michigan Division. **For:** Primary care physicians. **Cost:** $50. **Contact:** Melvin L. Reed, MD, FACP, Associate Professor, Department of Oncology, 4160 John R., Detroit 48201. **Approved for:** 12 hours of Category I Credit.

Date: April 17-21, Family Practice Review II. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Co-Sponsor:** Michigan Academy of Family Physicians. **Cost:** $250. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education*. **Approved for:** 37 hours of Category I Credit.

Date: April 25, Continuing Pathology Conference. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $20. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education*. **Approved for:** 6½ hours of Category I Credit.

Date: May 4-5, The High-Risk Infant. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $75. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 12 hours of Category I Credit.

Date: May 22-26, Internal Medicine. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $250. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education*. **Approved for:** 33½ hours of Category I Credit.

Date: May 24, Meadow Brook Lecture Series in Medicine and Surgery, "The Current Status of the Coronary Bypass Operation." Location: Meadow Brook Hall, Rochester. **Sponsor:** Oakland Health Education Program. **For:** All specialties. **Cost:** $75 for series, $20 each lecture. **Contact:** Gail Anne Rassier, Administrative Secretary, Oakland Health Education Program, 268 South Foundation Hall, P.O. Box 84, Rochester 48063. **Approved for:** 2 hours of Category I Credit.

June 8-10, Keyport-Gaylord Trauma Symposium. Location: Gaylord. **Sponsor:** WSU School of Medicine. **For:** All specialties. **Cost:** $25. **Contact:** Wayne State University, Division of CME.** **Approved for:** 12 hours of Category I Credit.

Date: June 25-30, Northern Michigan Summer Conference. Location: Shanty Creek Lodge, Bellaire. Sponsor: U-M Department of Postgraduate Medicine and Health Professions Education. **Cost:** $200. **Contact:** Floyd C. Pennington, PhD, U-M Office of Intramural Education.* **Approved for:** 21½ hours of Category I Credit.

Continuing Courses

Date: Continuing Quarterly Journal Club — Surgery. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Surgeons. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Monthly, Cleft Palate Clinic. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital****. **For:** Oral Surgeons, plastic surgeons, pediatricians. **Cost:** None. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 3 hours of Category I Credit.

Date: Monthly, Tissue Audit (Cancer). Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Surgeons, ob-gyns, pathology, radiology. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital of Detroit****. **Approved for:** 2 hours per session Category I Credit.

Date: Monthly Lecture Series in Ophthalmology. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Ophthalmologists. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Monthly, Ob/Gyn Journal Club. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** All interested physicians. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Monthly Urology Journal Club. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Urologists. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital**** **Approved for:** 2 hours of Category I Credit.

Date: Begins September, Continuing Training in Family Therapy. Location: Suite 1212, North Park Plaza, 17117 W. Nine Mile Road, Southfield. **Sponsor:** Family Institute of Southeastern Michigan. **Co-sponsor:** Ackerman Institute. **For:** Psychotherapists. **Cost:** Varies according to time put in. **Contact:** Carolyn R. Tourkow, MSW, director, Family Institute of Southeastern Michigan. **Approved for:** Hours vary with time spent.

Date: Every Tuesday — Psychiatry — Special Problems Seminar. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital. **For:** Psychiatrists. **Cost:** No charge. **Contact:** Office of CME, Sinai Hospital****. **Approved for:** 2 hours of Category I Credit.

Date: Every Tuesday morning, Gynecology/Obstetrics Combined Grand Rounds. Location: Jackson Auditorium, Hutzel Hospital. **Sponsor:** Wayne State University Department of Gynecology-Obstetrics. **For:** All interested physicians. **Cost:** No charge. **Contact:** Wayne State University, Division of CME**. **Approved for:** 4 hours each of Category I Credit.

Date: Tuesdays, GYN/OB Combined Grand Rounds. Location: Hutzel Hospital, Detroit. **Sponsor:** WSU School of Medicine. **For:** All specialties. **Contact:** Wayne State University, Division of CME.** **Approved for:** 4 hours of Category I Credit.

Date: 3rd Tuesday, Jan., March, and May, Detroit Cancer Club. Location: Wayne County Medical Society. **Sponsor:** WSU School of Medicine. **For:** All interested physicians. **Contact:** Wayne State University, Division of CME.** **Approved for:** 2 hours of Category I Credit.

Date: Last Tuesday of each month, December to May. Metropolitan Detroit Family Practice Behavioral Science Program. Location: Harper Hospital. **Sponsor:** WSU School of Medicine. **For:** All specialties. **Contact:** Wayne State University, Division of CME.** **Approved for:** 2 hours of Category I Credit.

Date: Each Wednesday, Detroit Medical Center Hand Conference. Location: Classroom 3, Second Floor, Webber Wing, Harper Hospital, Detroit. **Sponsor:** Wayne State University. **For:** Surgeons. **Cost:** No charge. **Contact:** Joseph L. Posch, MD, Fourteenth Floor, Kales Building, 76 W. Adams, Detroit 48226. **Approved for:** Hour-for-hour Category I credit.

CATEGORY I COURSES/*Continued*

Date: Wednesdays, Jan. 11 - March 29, Clinical Nuclear Medicine. Location: Scott Hall, WSU, Detroit. **Sponsor:** WSU School of Medicine. **For:** All specialties. **Cost:** $66. **Contact:** Wayne State University, Division of CME.** **Approved for:** 18 hours of Category I Credit.

Date: Wednesdays, Jan. 18 - April 26, Dermatologic Immunology & Allergy. Location: Detroit General Hospital. **Sponsor:** WSU School of Medicine. **For:** All specialties. **Cost:** $40. **Contact:** Wayne State University, Division of CME.** **Approved for:** 15 hours of Category I Credit.

Date: Wednesdays, April 5 - June 14, Clinical Nuclear Medicine II. Location: Scott Hall, WSU, Detroit. **Sponsor:** WSU School of Medicine. **For:** All specialties. **Cost:** $66. **Contact:** Wayne State University, Division of CME.** **Approved for:** 18 hours of Category I Credit.

Date: Wednesdays, Dermatology Grand Rounds. Location: Detroit General, Harper, and Allen Park VA Hospitals. **Sponsor:** WSU School of Medicine. **For:** All specialties. **Contact:** Wayne State University, Division of CME.** **Approved for:** 2 hours of Category I Credit.

Date: Wednesdays, Dec. through June, Cancer Seminars. Location: Harper Hospital, Detroit. **Sponsor:** WSU School of Medicine. **For:** All specialties. **Contact:** Wayne State University, Division of CME.** **Approved for:** 2 hours of Category I Credit.

Date: Wednesdays, 8 sessions per year, Detroit Physiological Society. Location: WSU School of Medicine, Scott Hall, Detroit. **Sponsor:** WSU School of Medicine. **For:** All specialties. **Contact:** Wayne State University, Division of CME.** **Approved for:** 2 hours of Category I Credit.

Date: Every other Wednesday, Pediatric Oncology Conference. Location: Children's Hospital of Michigan, Detroit. **Sponsor:** WSU School of Medicine. **For:** All specialties. **Contact:** Wayne State University, Division of CME.** **Approved for:** 2 hours of Category I Credit.

Date: Thursdays, through December, Current Ophthalmology. Location: Kresge Eye Institute, 3994 John R., Detroit. **Sponsor:** Kresge Eye Institute of Wayne State University. **For:** Practicing ophthalmologists. **Cost:** None. **Contact:** Kresge Eye Institute of Wayne State University Detroit. **Approved for:** 2 hours of Category I Credit.

Date: Thursdays, through March 9, Postgraduate Seminars in Pediatrics. Location: William Beaumont Hospital, Royal Oak. **Sponsor:** Department of Pediatrics, William Beaumont Hospital. **For:** Pediatricians. **Cost:** $100 (full series), $10 each lecture. **Contact:** Ms. Liz Ketschmann, 313/288-7225. **Approved for:** 2 hours of Category I Credit each session.

Date: Second Thursday of each month, Inter-Hospital Pathology Slide Conference. Location: St. John Hospital, Detroit. **Sponsor:** St. John Hospital. **For:** Pathologists. **Cost:** No charge. **Contact:** Department of CME, St. John Hospital, 22101 Moross Road, Detroit, 48236, (313) 881-8200. **Approved for:** 3 hrs. each date Category I Credit.

Date: First Friday of month, Pathology Journal Club. Location: Allen Park VA Hospital. **Sponsor:** WSU School of Medicine. **For:** All interested physicians. **Contact:** Wayne State University, Division of CME.** **Approved for:** 2 hours of Category I Credit.

Date: Last Friday of month, Clinical Laboratory Case of the Month. Location: Allen Park VA Hospital. **Sponsor:** WSU School of Medicine. **For:** All specialties. **Contact:** Wayne State University, Division of CME.** **Approved for:** 2 hours of Category I Credit.

Date: Fridays, Urology Grand Rounds and Teaching Seminars. Location: Hutzel Hospital, Detroit. **Sponsor:** WSU School of Medicine. **For:** All specialties. **Contact:** Wayne State University, Division of CME.** **Approved for:** 2 hours of Category I Credit.

Date: Fridays, Neurology Conference. Location: Harper Hospital, Detroit. **Sponsor:** WSU School of Medicine. **For:** All specialties. **Contact:** Wayne State University, Division of CME.** **Approved for:** 2 hours of Category I Credit.

Date: Monthly, Saturdays - Sundays, Intensive Training in Family Therapy. Location: Southfield. **Sponsor:** The Family Institute of Southeastern Michigan. **Co-Sponsor:** Ackerman Family Institute of New York. **For:** Psychiatrists. **Cost:** $2,500 per year. **Contact:** Carolyn R. Tourkow, MA, MSW, Suite 1212, North Park Plaza, 17117 West Nine Mile Road, Southfield, 48075. **Approved for:** 120 hours of Category I Credit (must go to all sessions).

Date: Monthly, Saturdays, Intermediate Training in Family Therapy. Location: Southfield. **Sponsor:** The Family Institute of Southeastern Michigan. **Co-Sponsor:** Ackerman Family Institute of New York. **For:** Psychiatrists. **Cost:** $25. **Contact:** Carolyn R. Tourkow, MA, MSW, Suite 1212, North Park Plaza, 17117 West Nine Mile Road, Southfield, 48075. **Approved for:** 3 hours of Category I Credit.

Date: Every Saturday, Weekly Conference. Location: Gamble Building, Burns Clinic / Little Traverse Hospital, Petoskey. **Sponsor:** Burns Clinic. **For:** All interested physicians. **Cost:** None. **Contact:** A. D. Damschroder, MD, Chairman, Burns Clinic Medical Center, Petoskey 49770. **Approved for:** Hour-for-hour Category I Credit.

Date: Saturdays, Morbidity and Mortality Conference. Location: Sinai Hospital of Detroit. **Sponsor:** Sinai Hospital Department of Surgery. **For:** Surgeons. **Cost:** None. **Contact:** Office of CME, Sinai Hospital of Detroit**** **Aproved for:** 2 hours of Category I Credit per session.

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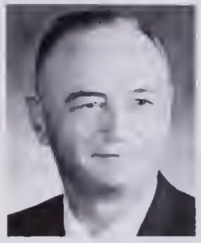
*Office of Intramural Education, University of Michigan Medical Center, Dep't. of PBM/HPE, Ann Arbor, 48109.

**WSU Division of CME, Room 1209, Scott Hall, 540 E. Canfield, Detroit, 48201 (313) 577-1453

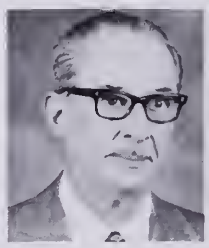
***Richard W. Pomeroy, MD, Director of Medical Education, E. W. Sparrow Hospital, 1215 E. Michigan Ave., Lansing, 48902

****Department of CME, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 493-5097.

Letters



Sam Sugar, MD



Saul Sugar, MD

Correction

I am writing in regards to the picture printed in the October issue of MSMS in the article Heartbeat. The picture you have printed is of myself and not of Saul Sugar, MD. I wish for him to receive the recognition he deserves, so I am writing to let you know you have the wrong picture printed.

Thanks for the publicity.

Sam Sugar, MD

(Editor's note: Saul Sugar, MD, was cited recently by the State of Israel, as reported in the October Michigan Medicine. *We thank Sam Sugar, MD, for the photo correction.)*

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***Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:
Possibly Effective:
1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.

Final classification of the less-than-effective indications requires further investigation.

Composition: Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.
Vasodilan injection, isoxsuprine HCl, 5 mg., per ml.

Dosage and Administration: Oral: 10 to 20 mg., three or four times daily. Intramuscular: 5 to 10 mg. (1 or 2 ml.) two or three times daily. Intramuscular administration may be used initially in severe or acute conditions.

Contraindications and Cautions: There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

Parenteral administration is not recommended in the presence of hypotension or tachycardia.

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Adverse Reactions: On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

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Supplied: Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls. U.S. Pat. No. 3,056,836

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Two Michigan physicians served on committees during the 1977 Interim Meeting of the AMA House of Delegates in Chicago, December 4-7. **Donald K. Crandall, MD, Muskegon,** has been appointed to the Credentials Committee and **Frank B. Walker, II, MD, Grosse Pointe Farms,** will be a member of Reference Committee H.

Roy Dalton Diggs, Jr., MD, Flint, recently was in the *Flint Journal* spotlight, praised for his fine service as a neurosurgeon and also for career advice and encouragement he provides to young people.

Robert N. Frank, MD, associate professor of ophthalmology at WSU School of Medicine, is the recipient of the Fight for Sight Citation. The Association for Research in Vision and Ophthalmology honored Doctor Frank for his studies of the blood platelets and a substance called "von Willebrand factor" found in the blood of long-duration diabetes patients.

Among Michigan physicians holding office on national specialty boards is **Sidney Friedlaender, MD, Southfield,** who is secretary of the American Board of Allergy and Immunology.

Two gastroenterologists at Providence Hospital, Southfield, **Eugene A. Gelzayd, MD,** and **Luis Maas, MD,** have received the H. Allen Barth Award in recognition of their development of a home hyperalimentation program which saves $43,800 per patient, per year. The award is part of the "Share Our Savings" (S.O.S.) annual contest sponsored by the Michigan Hospital Association and Blue Cross/Blue Shield of Michigan. The program is designed to help cut hospital costs by recognizing hospital employees whose suggestions save their institution money through improved operating methods.

The new director of the Washtenaw County League for Planned Parenthood is **A. Alberto Hodari, MD.** Doctor Hodari previously served as director of the obstetrics-gynecology residency program at St. Joseph Hospital in Detroit.

The U-M Hypertension Division paid tribute to **Sibley W. Hoobler, MD,** at a symposium on hypertension named in his honor at Towsley Center in Ann Arbor. Doctor Hoobler served as director of the U-M Hypertension Clinic for 30 years, prior to moving to Cleveland a year ago where he is pursuing hypertension research at Cleveland Clinic and serves as clinical professor of medicine at Case Western Reserve University. Doctor Hoobler also is well known for his work in the preservation of Michigan wilderness areas and his philanthropic activities through the Madge and Raymond Hoobler Memorial Corporation.

MSMS President **Vernon V. Bass, MD,** presented the Society's "Presidential Citation" to **Andrew D. Hunt, Jr., MD,** at a dinner honoring his service as the first dean of the MSU College of Human Medicine. Doctor Bass lauded Doctor Hunt as "the complete physician."

The new president of the Metropolitan Northwest Detroit Hospitals Corporation is **Frederick W. Hyde, Jr., MD, Lathrup Village.** The Corporation known as the Quadrangle includes Grace, Providence, Sinai and Mt. Carmel Hospitals, and was incorporated in 1972 to reduce hospital costs and improve services to patients through cooperative programs.

Clarence S. Livingood, MD, Detroit, has been appointed to the AMA Liaison Committee on Graduate Medical Education.

Four WSU School of Medicine faculty members completed the 26-mile Boston Marathon Run: **Doctors Lawrence Power, Joseph Arends, Charles Lucas,** and **Earl Rudner.** All are members of the American Medical Joggers Association.

R. Gerald Rice, MD, Michigan public health official, received the American Public Health Association's prestigious Martha May Eliot Award for unusual achievement in the field of maternal and child health. Special recognition was given to Doctor Rice for his contributions to the crippled children's program in Michigan.

Kenneth E. Rowe, MD, is new health officer/medical director of the Dickinson-Iron District Health Department, in addition to his current responsibilities with the Western Upper Peninsula District Health Department.

Doctor Wilson new board president

Grand Rapids pediatrician John R. Wilson, MD, is new head of the Michigan Medical Practice Board.

Doctor Wilson, 48, has served on the 13-member panel board since 1971.

He is chief of staff and a member of the board of trustees at Butterworth Hospital, and is past president Michigan Chapter, American Academy of Pediatrics.

He succeeds Frederick W. VanDuyne, MD, Flint, who decided not to seek reappointment to the board.

Donald H. Kuiper, MD, Lansing, is new vice-president of the board. He is presently on the staff of St. Lawrence Hospital and was formerly on the faculty of the Michigan State University College of Human Medicine.

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☐ **Appropriate antibacterial therapy:** up to three days therapy with Azo Gantanol, then 11 days with Gantanol® (sulfamethoxazole), 0.5 Gm tablets.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies.

Note: **Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

Note: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

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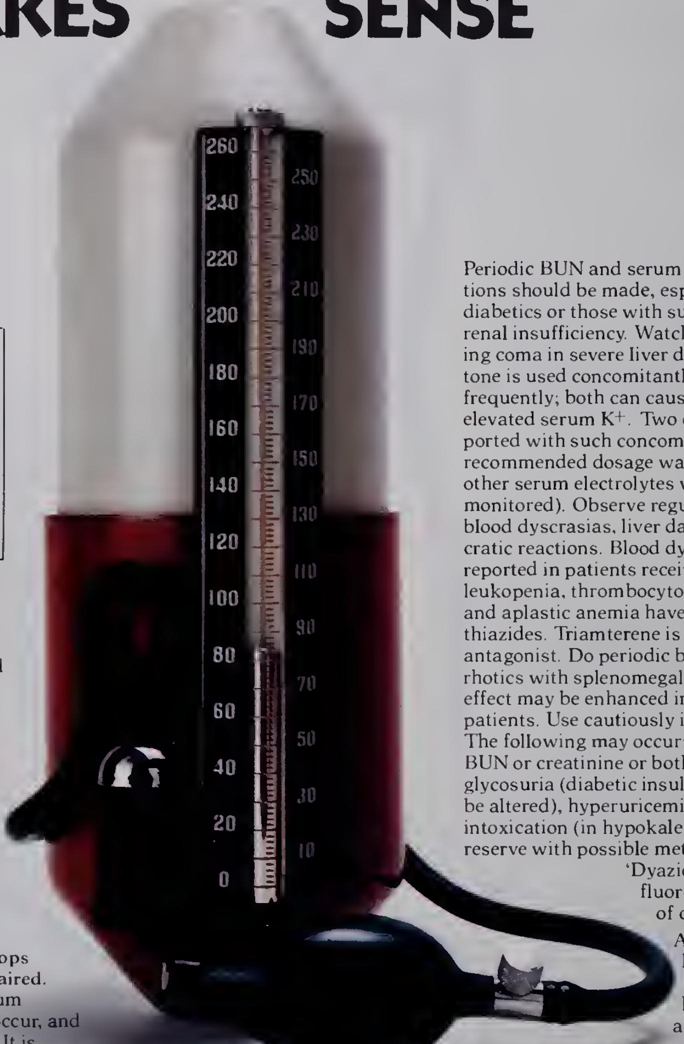

Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* Warning
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium sparing action of triamterene is warranted. (See Box Warning.) Routine use of diuretics in healthy pregnant women is inappropriate; they are indicated in pregnancy only when edema is due to pathological causes.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K$^+$ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K$^+$ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K$^+$ frequently; both can cause K$^+$ retention and elevated serum K$^+$. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 and 1000 capsules; Single Unit Packages of 100 (intended for institutional use only).

FOR LONG-TERM CONTROL OF HYPERTENSION.*
SERUM K$^+$ AND BUN SHOULD BE CHECKED PERIODICALLY.
(SEE WARNINGS SECTION.)

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Escherichia
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Streptococcus
Pneumococcus

Bacitracin

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Corynebacterium
Streptococcus
Pneumococcus

Polymyxin B

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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Wanted Movies of Ceremony, But Both Factions Are

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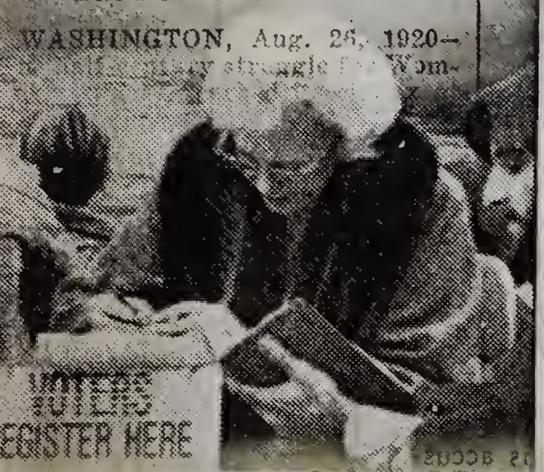

Social Security Bill Is Signed; Gives Pensions to Aged, Jobl

Roosevelt Approves Message Intended to Benefit 30,000 Persons When States Adopt Cooperating Laws—He Ca the Measure 'Cornerstone' of His Economic Program

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WASHINGTON, Aug. 14, The Social Security Bill, prov a broad program of unemploy insurance and old age pen and counted upon to benefit 20,000,000 persons, became la day when it was signed by dent Roosevelt in the presen those chiefly responsible for ting it through [illegible].

Mr. Roosevelt ca[illegible] me "the cornerstone [illegible] stru whi[illegible] is being [illegible] me[illegible]s comple [illegible] ri[illegible] to [illegible]

SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution is Sent to House, Where Passage is Expected

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WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sen[illegible] to

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TRUMAN CLOSES TED NATIONS CONFEREN ITH PLEA TO TRANSLATE CHARTER INTO DEEDS

NEW WORLD HOPE

President Hails 'Great Instrument of Peace,' Insists It Be Used

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HISTORIC LANDMARK

Meeting Gives Standing Ovation as Executive Pictures Peace Gain

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"If we fail to use it," he declared to the solemn final meeting of the delegates, 'we shall betray all of those who have died in order that we might meet here in freedom and safety to create it.'

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

Fervent Interpolation

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session the President accompanied the eight United States delegates to

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SIGNE

the Draf Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the Secretary of the Army that he foresees no need for

PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.

The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.

The Advantages

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

The Disadvantages

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

The Solution

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

PMA
THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION
1155 FIFTEENTH ST, N W, WASHINGTON, D. C. 20005

Good communication the key to building doctor-patient relationship

(The following is the first in a series of articles on risk management to appear in Michigan Medicine *in coming months. It is sponsored by the MSMS Committee on Professional Liability, chaired by Robert M. Leitch, MD, Battle Creek, MSMS immediate past president. The material was originated with the Illinois State Medical Society, which has prepared tape cassettes on the subject.)*

The new MSMS Committee on Professional Liability was formed in late summer this year by MSMS Past President Robert M. Leitch, MD, Battle Creek, to educate physicians and help them avoid situations which might lead to litigation. On the committee are MSMS Past President Brock E. Brush, MD, Detroit; John F. Fennessey, MD, Grosse Pointe; Oliver D. Grin, Jr., MD, Grand Rapids; Frederick V. Minkow, MD, Bloomfield Hills; Rhoda F. Powsner, MD, Ann Arbor, and J. A. Sentkeresty, MD, Grand Rapids.

You may think you're providing the best medical care possible, but if the patient isn't convinced, he may show his displeasure with a malpractice suit. That's why good communication is extremely important, from the time you accept a patient until you withdraw from the case.

Before you accept a new patient, outline the extent and nature of your practice. Discuss your fees and clearly explain to the patient the risks involved in any kind of treatment. If possible, have the patient sign a statement acknowledging receipt of this information.

If you're unable to reach an understanding about any of these items — or if you believe the patient is a potential litigant — you may reject him. However, *once you accept a patient, you are legally responsible for his continued care.*

Good communication is particularly important when a case is not progressing favorably. You must guard against losing the patient's confidence.

- Discuss the situation frankly. Usually the patient is aware that a problem exists, and he often assumes the worst. A detailed explanation may allay some of those fears.

- Explain alternate courses of treatment, and don't hesitate to suggest consultation with another physician.

- Handle inquiries from relatives with tact, patience and common sense. But keep in mind the confidential nature of your relationship with the patient. If legitimate questions are raised about a specific course of treatment, hold an informal conference with the concerned party and the medical personnel involved.

It is extremely important to carefully explain your fees. This can prevent misunderstandings which often lead to legal action. Keep three basic guidelines in mind:

- Before ordering any elaborate or extensive treatment, tell the patient what your fees will be and explain the other costs involved. Ideally, you should ask the patient to sign a financial agreement.

- Use discretion in dealing with a patient who is delinquent in paying your bill. The wrong approach could anger him and precipitate legal action. A patient with financial difficulties who is making payments to meet his obligations deserves special consideration.

- Exercise extreme caution if you believe the patient has doubts about your bill or the treatment. Those doubts may be unjustified, but don't press for payment until you have had an opportunity to discuss the matter.

Always inform your patients about any vacation or other temporary absence, and make sure another physician is available during these periods. When you decide to permanently withdraw from a case, it is advisable to notify the patient by certified mail and to keep a copy of that notice and the mail receipt in your records. Advise the patient to obtain a replacement, but emphasize that you will delay your withdrawal until another physician is retained. *Never withdraw from a case until you or the patient has obtained an adequate replacement.*

Finally, when treating a patient who has been under the care of another physician, avoid disparaging comments if you do not agree with the prior care. The previous treatment may have been proper, so you must investigate and analyze the situation thoroughly. Impulsive, unjustified comments may trigger a suit. And remember, unfavorable comments can be made without uttering a word. In fact, a grimace, gesture or frown can sometimes speak louder than words.

Robert M. Leitch, MD, head of table, presides over initial meeting of new MSMS Committee on Professional Liability. Doctor Leitch is immediate past MSMS president. From left around the table are MSMS President Vernon V. Bass, MD; 1975-1976 MSMS President Brock E. Brush, MD; John F. Fennessey, MD, JD, Grosse Pointe; Frederick V. Minkow, MD, Bloomfield Hills, and Louis E. Heideman, MD, MSMS president-elect.

If you discover poor practice by a fellow physician, provide necessary treatment to the patient without encouraging a suit, and confront the offending physician so that the problems are corrected.

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Virginia survey uncovers these hints for minimizing malpractice risk

A recent survey of patient complaints against physicians in the Richmond, VA area, prompted the surveyors to make the following suggestions to physicians to help them lessen their liability risks. These suggestions first were published in the Dec. 6, 1976 issue of the Journal of the American Medical Association. *(Author of the article is Charles L. Cooke, MD, Richmond.)*

1. Never guarantee results of therapy, for unpredictability of disease processes and human behavior make it impossible to do so. Even if it were possible to guarantee results, there would still be some people who would be dissatisfied with the situation. Always discuss the prognosis of the disease involved, and be certain to mention possible complications of therapy. If these complications are unusual or possibly severe, then written instructions in the form of a letter to the patient would be helpful.

2. Set fees commensurate with the difficulty of the problem involved and with the amount of time spent. Spell this out clearly beforehand, and itemize all bills to show which portion of the fee is for professional services, laboratory studies, roentgenograms, ECGs, and other tests or services.

3. Be certain that your answering service clearly knows who is substituting for you if you are gone.

4. Be certain to return calls to patients promptly, especially if the patient is dissatisfied with your services or with the results of therapy. It is far better that patients talk to the physician involved than that they talk to neighbors, malpractice lawyers, or the Mediations Committee. Deal openly and directly with the patient's specific complaint.

5. Do not hesitate to ask for a consultation if the patient or family seems to question your diagnosis or therapy. If you are correct, the consultation will only make you look better; if you are wrong, you stand to learn something.

6. Deal with the patient's family with special consideration. If members of the family are in allied health professions, they are far more likely to precipitate complaints.

7. Think twice before sending a bill to a collection agency, especially if the patient has a reason to be dissatisfied with your services.

8. If you encounter patients you cannot learn to like, help them find another physician. No complaints were written by patients who were satisfied with the personal relationship with their physician.

9. More active use of mediations committees would help.

10. Finally, and perhaps most important, most complaints of patients directed against physicians could be prevented by improved communications, common courtesy, and the willingness to listen on the part of both parties involved.

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Rep. Cawthorne

By Willah Weddon
Special to Michigan Medicine

As leader of the Republican party in Michigan's House of Representatives, Rep. Dennis O. Cawthorne frequently plays a key role in the development of Governor William G. Milliken's health care proposals.

"I helped expedite passage of the new public health code when it was in the House," the youthful-appearing legislator from Muskegon pointed out. "Basically this is a good mechanism to reorganize health care legislation in a way that will benefit both consumers and providers."

Quiet effectiveness

The fact that the proposed new code was adopted by a 73 to 23 vote in the House, which is split by a Democrat majority of 68 to the Republican's 42, is a firm indication of Cawthorne's effectiveness. Although he usually works quietly behind the scenes, the Harvard Law School graduate occasionally challenges his opposition on the floor of the House in strong, pointed remarks that leave an impact.

"As to the roles of other health professions, I think it is important that various disciplines stick to their own field so we don't have untrained or incompetent people trying to practice medicine," he contends.

Within the medical profession, however, Cawthorne feels better use should be made of physician extenders to support group practice; physician assistants and nurse practitioners should be used more extensively and assistance should be given to develop training programs for other health professionals to care for patients in non-acute phases of illness.

He also favors correcting the disparity of payment by third party payors that exists for the same procedures in different parts of the state.

Medicaid cost restraints

"I have been very interested in developing better restraints on the Medicaid cost spiral," he continued, "and in developing workable controls on excess hospital beds."

Cawthorne defines "workable" in this instance as a method of control which does not impose rigid rules in areas where there may be good reasons for exceptions or variations. He referred to the recent incident in Jackson County when the Odd Fellows and Rebekah Home organization was denied a permit to expand because the area already has enough beds, according to federal guidelines. "No recognition was given the fact that the home is maintained for members of the fraternal order from throughout the state," he pointed out, adding, "It is owned, operated and maintained by the organization which has a long waiting list of persons seeking admission."

The following article is the fourth in a series. The articles, written especially for *Michigan Medicine* by Lansing-area free-lancers, profile Michigan legislators who are key figures in the formulation of health care legislation and programs.

Elected to the legislature in 1966 at the age of 26, Cawthorne had been admitted to the State Bar that same year. He is currently a member of the Board of Trustees at Albion College, where he did his undergraduate work, and is a member of the State YMCA Board of Directors. Young, energetic and ambitious, his name has been included in the past among those under consideration by the Governor for the Lt. Governor's post. He is expected to be in the field again next year, unless he makes a bid for the U.S. Senate seat on the Republican ticket.

Or, if Gov. Milliken does not seek re-election, Cawthorne's name will very likely appear in the primary race as a gubernatorial candidate.

Recombinant DNA research underway at U-M

With the certification of specially renovated facilities in the Medical Science II complex, The University of Michigan's first P-3 level (moderate risk) recombinant DNA experiments were given the go-ahead Oct. 29.

Professors Roy Schmickel and Golder Wilson, both in the department of pediatrics and communicable diseases, will now be permitted to proceed with the project, "Isolation and Characterization of Human Ribosomal DNA." The project involves splicing together genetic material of human cells and bacterial viruses to learn more about the genes involved in cellular protein synthesis.

Recombinant DNA experiments join genetic material from organisms of different species, resulting in combinations that are not known to occur in nature. Due to the possible dangers of the technique, the National Institutes of Health had developed guidelines for such experimentation. The P-3 code denotes the second most stringent of four levels of laboratory physical-containment protection.

To comply with the federal guidelines, the U-M formed a group of faculty scientists and community representatives — Committee C — to monitor the safety of recombinant DNA experimentation on campus.

According to Committee C Chairman Francis Payne, professor of epidemiology, "an extensive series of tests and inspections has satisfied us that the Med Sci II facility is in compliance with federal safety standards.

"Recombinant DNA is a new set of tools, rather than a new area," Payne observes. "So far as we know, there have been no accidents, no illnesses anywhere in the world attributable to recombinant DNA research."

Another P-3 level research facility has been equipped at the U-M, and a third is being readied.

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Meetings

(See also listing of Category I programs on page 614.)

Jan. 12 — "Post Retirement Employment Opportunities for Physicians," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

Jan. 25 — MSMS/INTRAV South American Adventure, contact: Marce Ireland, MSMS headquarters.

Feb. 3-10 — Michigan Doctors Study Club, Study/Ski Seminar, Snowmass/Aspen, contact: Thomas R. Berglund, MD, ℅ M. Guerin Tours, Inc., P.O. Box 868, Port Huron, MI 48060, 313/987-7370.

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Tel. 616-459-9134
Manager: Fred Jirous

Feb. 9 — "Investments for Retirement Income," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

Feb. 24-Mar. 3 — Michigan Doctors Study Club, Study/Ski Seminar, Vail, contact: Thomas R. Berglund, MD, ℅ M. Guerin Tours, Inc., P.O. Box 868, Port Huron, MI 48060, 313/987-7370.

March 8-9 — Conference on Maternal and Perinatal Health, Hyatt Regency Dearborn, contact: Herbert Auer, MSMS headquarters.

March 24-31 — Michigan Doctors Study Club, Study/Ski Seminar, Snowmass, contact: Thomas R. Berglund, MD, ℅ M. Guerin Tours, Inc., P.O. Box 868, Port Huron, MI 48060, 313/987-7370.

April 13 — Annual Michigan Conference on Medical Aspects of Organized Athletics, Long's Convention Center, Lansing, contact: Herb Auer, MSMS headquarters.

April 13 — "The Physician's Family," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

May 1-3 — Auxiliary Annual Convention, Bay Valley Inn, Bay Valley, contact: Helen Schulte, MSMS headquarters.

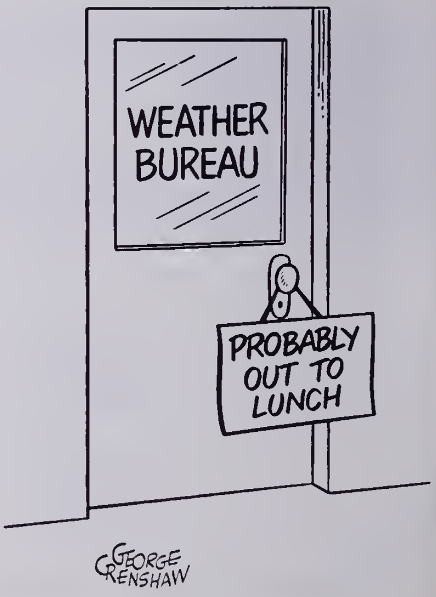
May 5-7 — Annual MSMS House of Delegates meeting, Hyatt Regency Dearborn, contact: Dick Campau, MSMS headquarters.

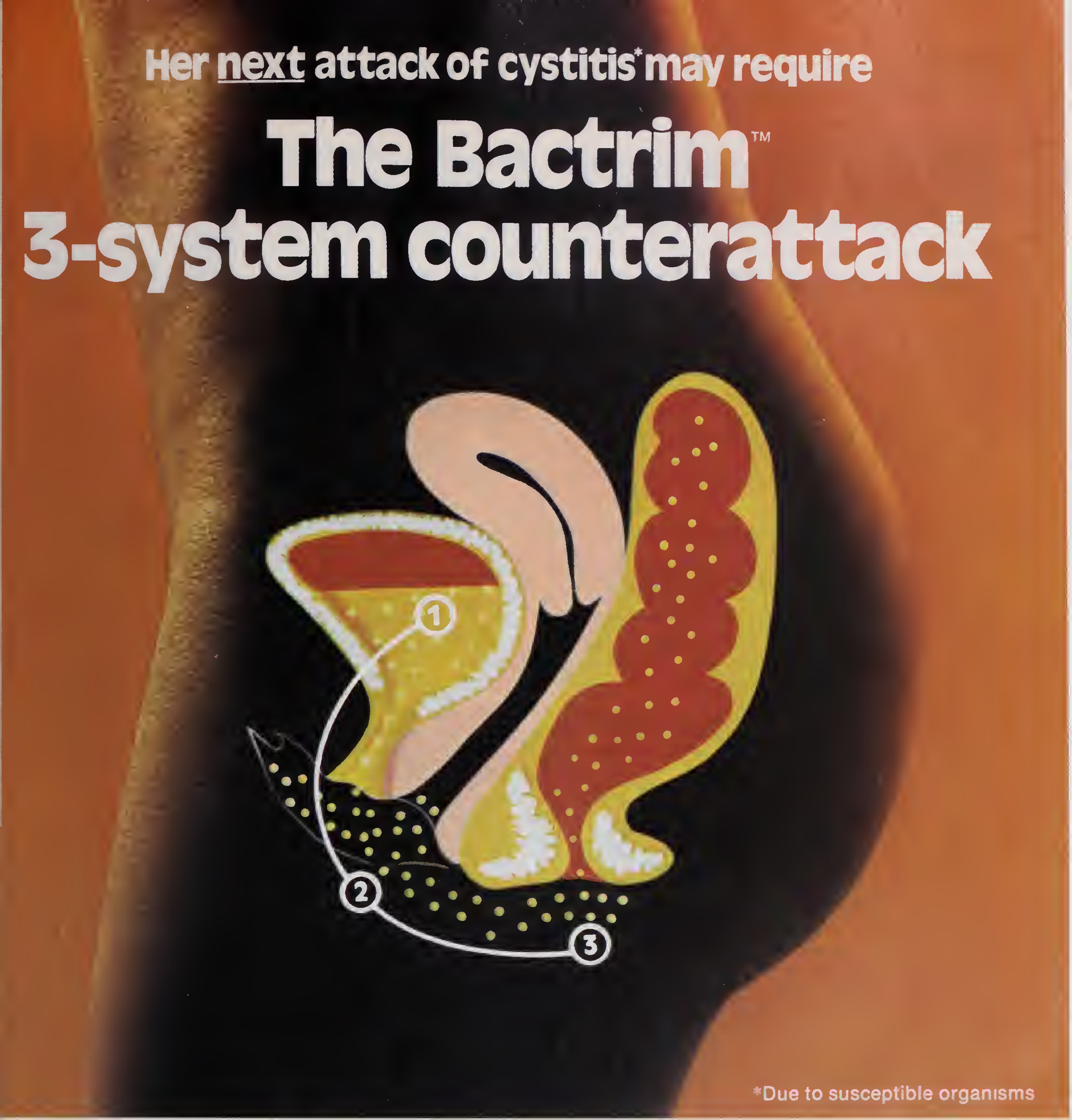
June 15 — "Insurance Programs for Family Protection and Retirement Income," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

Sept. 14 — "Legal Problems of Ending Medical Practice," presented by St. John Hospital, Dept. of Health Education in Cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

Oct. 12 — "Pre and Post Retirement Medical Care for the Physician and His Family," presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-8200, Ext. 321.

Nov. 23 — "How Do I Know When to Retire?" presented by St. John Hospital, Dept. of Health Education in cooperation with the Wayne County Medical Society, contact: St. John Hospital, Health Education Dept., 313/881-3200, Ext. 321.

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The Bactrim™
3-system counterattack
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3

*Due to susceptible organisms

Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Bactrim™ DS Double Strength Tablets

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Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Please see reverse side for summary of product information.

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Just one tablet b.i.d. for 10 to 14 days

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- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older:

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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In Memoriam

George M. Baker, MD
Parma

George M. Baker, MD, a Parma physician, died Sept. 29 at 69 years of age. Doctor Baker was a staff member at Foote Hospital East and Foote Hospital West. He was a member of the board of the Beth Moser Mental Health Clinic, and was medical director of the Jackson County Medical Care Facility. He also was past president of the Jackson County Medical Society.

Albert Bloom, MD
Southfield

Albert Bloom, MD, age 75, of Southfield, a general practitioner in Detroit, died Oct. 10. Born in Russia, Doctor Bloom was a graduate of the University of Michigan Medical School and was on the staffs of Grace and Harper Hospitals, Detroit.

Eugene R. Elzinga, MD
Marquette

Eugene R. Elzinga, MD, of Marquette, died Aug. 18 at the age of 80. A specialist in orthopaedic surgery, Doctor Elzinga graduated from the University of Michigan Medical School and was affiliated with St. Luke's Hospital, Marquette. He was a fellow of the American College of Surgeons, American Academy of Orthopaedic Surgeons, and the American Academy for Cerebral Palsy. He also was a member of the Clinical Orthopedic Society and was a past president of Marquette-Alger County Medical Society. Doctor Elzinga was a former MSMS council member.

Isidor H. Friedman, MD
Southfield

Isidor H. Friedman, MD, 80, a family practitioner in Detroit, died Oct. 27. A resident of Southfield, Doctor Friedman was the former owner of Trumbull General Hospital and one of the founders of Southwest Detroit General Hospital. Doctor Friedman graduated from University of Michigan Medical School and was the first doctor to administer insulin in Michigan.

C. M. Hardy, MD
Dearborn

C. M. Hardy, MD, an obstetrician/gynecologist at Oakwood Hospital, Dearborn, died Oct. 20 at the age of 55. Doctor Hardy graduated from Dalhousie Medical School in Halifax, Nova Scotia. He was a former chief of staff for gynecology and obstetrics at Oakwood.

Charles L. Hodge, MD
Reading

Charles L. Hodge, MD, 82, of Reading, died Oct. 8. Doctor Hodge was a graduate of Wayne State University School of Medicine. He was affiliated with Hillsdale Community Health Center, Hillsdale and was a past president of Hillsdale County Medical Society.

Marie Keilin, MD
Muskegon

Marie Keilin, MD, Muskegon, died Sept. 22 at 91 years of age. Doctor Keilin served as pathologist at Hackley Hospital, and later was a general practitioner at both Hackley and Mercy hospitals. Born in Russia, Doctor Keilin and her family settled in Poland after being exiled from Russia. She received her medical degree from the University of Paris, and later attended the Pasteur Institute where she specialized in pathology. Doctor Keilin was honored by the MSMS for having completed 50 years of medical practice.

Klaire V. Kuiper, MD
Grand Rapids

Klaire V. Kuiper, MD, 61, a part-time psychiatrist at Pine Rest Christian Hospital, Grand Rapids, died Oct. 15. A graduate of Rush Medical University of Chicago, Doctor Kuiper served as the medical director at Bethesda Hospital in Denver and practiced in Grand Haven with the Citizen Mental Health Council. He was a member of the American Psychiatric Association, the West Michigan Psychiatric Association, the Christian Association of Psychiatry and the Christian Medical Society.

Morey Manning, MD
Southfield

Morey Manning, MD, Southfield, died Sept. 9 at 66 years of age. A graduate of Wayne State University School of Medicine, Doctor Manning was an internist. He was a Fellow of the Academy of Psychosomatic Medicine.

John R. McDonald, MD
Detroit

John R. McDonald, MD, an emeritus member of the medical staff of Harper-Grace hospitals, Detroit, died Oct. 18 at the age of 67. Doctor McDonald was chief of pathology and chief of staff at Harper Hospital. He was professor of pathology at the Mayo Graduate School of Medicine and Wayne State University. Doctor McDonald received his MD degree from the University of Manitoba, Canada. He was a national expert in pulmonary pathology and cytology as well as in general surgical pathology, and published a total of 263 articles in national publications. He had served as president of the Michigan Society of Pathologists and the Detroit Academy of Medicine. He was a Fellow of the College of American Pathologists and the American Society of Clinical Pathologists. Doctor McDonald received the American Cancer Society Award for Distinguished Service in Cancer Control, and the Papanicolaou Award of the American Society of Cytology.

Don W. McLean, MD
Lathrup Village

Don W. McLean, MD, 77, well-known Detroit area physician died Oct. 15. A proctologist, Doctor McLean was instrumental in the development of a rapid screening method for the detection of rectal cancer. He graduated from Wayne State University School of Medicine. Doctor McLean was president of the

MONTHLY SURVEILLANCE REPORT

Cases of Certain Diseases
Reported to the Michigan Department of Public Health

For the Four-Week Period Ending Oct. 28, 1977

	1977 This 4-Week Period	1976 Same 4-Week Period	1977 Total To Above Date	1976 Total Same Date	Total Cases for 1976
Rubella	42	28	971	1,405	1,513
Cong. Rubella Syndrome	0	0	3	0	2
Measles	57	29	1,005	5,877	6,139
Whooping Cough	10	3	64	61	70
Diphtheria	0	0	0	0	0
Mumps	119	98	1,953	4,943	5,507
Scarlet Fever & Strep Sore Throat	1,744	1,786	24,301	19,675	24,937
Tetanus	0	1	2	2	3
Poliomyelitis (paralytic)	0	0	0	1	1
Hepatitis	185	243	2,259	2,192	2,645
Salmonellosis (other than S. typhi)	93	60	830	732	889
Typhoid Fever (S. typhi)	2	1	12	9	10
Shigellosis	15	31	314	459	550
Aseptic Meningitis	36	31	165	137	163
Encephalitis	7	7	45	70	77
Meningococcic Meningitis	5	6	43	57	65
H. Influenzae Meningitis	10	9	127	105	134
Tuberculosis	86	97	1,080	1,139	1,357
Syphilis	78	87	942*	873	1,066
Gonorrhea	3,165	2,967	30,294	28,621	34,829

Information can be supplied by the local health department on local incidence of disease.

Maurice Reizen, M.D., Director
Michigan Department of Public Health

*Correction

IN MEMORIAM/*Continued*

Detroit Surgical Association, receiving their Distinguished Service Award; fellow of the American Academy of Surgery; past president of the Wayne County Medical Society; past president of the Wayne State University Medical Alumni Association; member of the board of directors for the Stapleton Fund for Medical Education; chief of the department of surgery at Grace Hospital; and assistant clinical professor of surgery at the Wayne State University School of Medicine. He was a former member of the MSMS Council and also of the Michigan Medical Practice Board.

Jason Bidwell Meads, MD
Jackson

Jason Bidwell Meads, MD, Jackson, died Oct. 10 at 81 years of age. A University of Michigan Medical School graduate, Doctor Meads was affiliated with W. A. Foote Memorial and Mercy hospitals. He was a past president of Jackson County Medical Society and served as Jackson County coroner.

Glenn F. Miller, MD
Saginaw

Glenn F. Miller, MD, 62, a Saginaw radiologist, died Oct. 23. Doctor Miller received his medical degree from the University of Nebraska. He was affiliated with St. Luke's, St. Mary's, Saginaw General and the VA Hospital, all of Saginaw. Doctor Miller was a member of the Radiological Society of North America and the Society of Nuclear Medicine.

Edwin Neill, MD
Grosse Pointe Woods

Edwin Neill, MD, Grosse Pointe Woods, died Oct. 20 at 63 years of age. A graduate of Wayne State University School of Medicine, Doctor Neill was director of medical education at Deaconess Hospital. He was on the staffs of Deaconess, Jennings and Alexander Blaine hospitals.

Clare A. Scheurer, MD
Pigeon

Clare A. Scheurer, MD, Pigeon, died Oct. 12 at age 71. A graduate of Northwestern University Medical School, Illinois, Doctor Scheurer built a medical clinic in Pigeon which later became Scheurer Hospital. He was a past president of the Huron County Medical Society and was a member of the American Academy of General Practitioners.

Walter A. Schmutzler, MD
Kingsford

Walter A. Schmutzler, MD, 56, of Kingsford, died Aug. 9. A staff physician at the Dickinson County Memorial Hospital, Doctor Schmutzler also served as a member of the MSMS Committee on Maternal and Perinatal Health.

Eugene L. Spoehr, MD
Ferndale

Eugene L. Spoehr, MD, Ferndale, died Oct. 5 at the age of 76. Doctor Spoehr practiced for many years in Ferndale and Pleasant Ridge and served as a staff member at Beaumont, Grace Central, Northwest Grace and Mt. Carmel Mercy hospitals. He was a graduate of Wayne State University School of Medicine.

Joseph C. Tiffany, Sr., MD
Grand Rapids

Joseph C. Tiffany, Sr., MD, Grand Rapids, died Oct. 21 at the age of 73. Doctor Tiffany was health director at two Grand Rapids neighborhood health services and was active in Northwestern University activities where he graduated from medical school. He was director of a medical relief program and was cited by President Franklin D. Roosevelt for his work as an examining physician of Selective Service. Doctor Tiffany founded the Michigan Society of Anesthesiology for which he served as secretary and treasurer.

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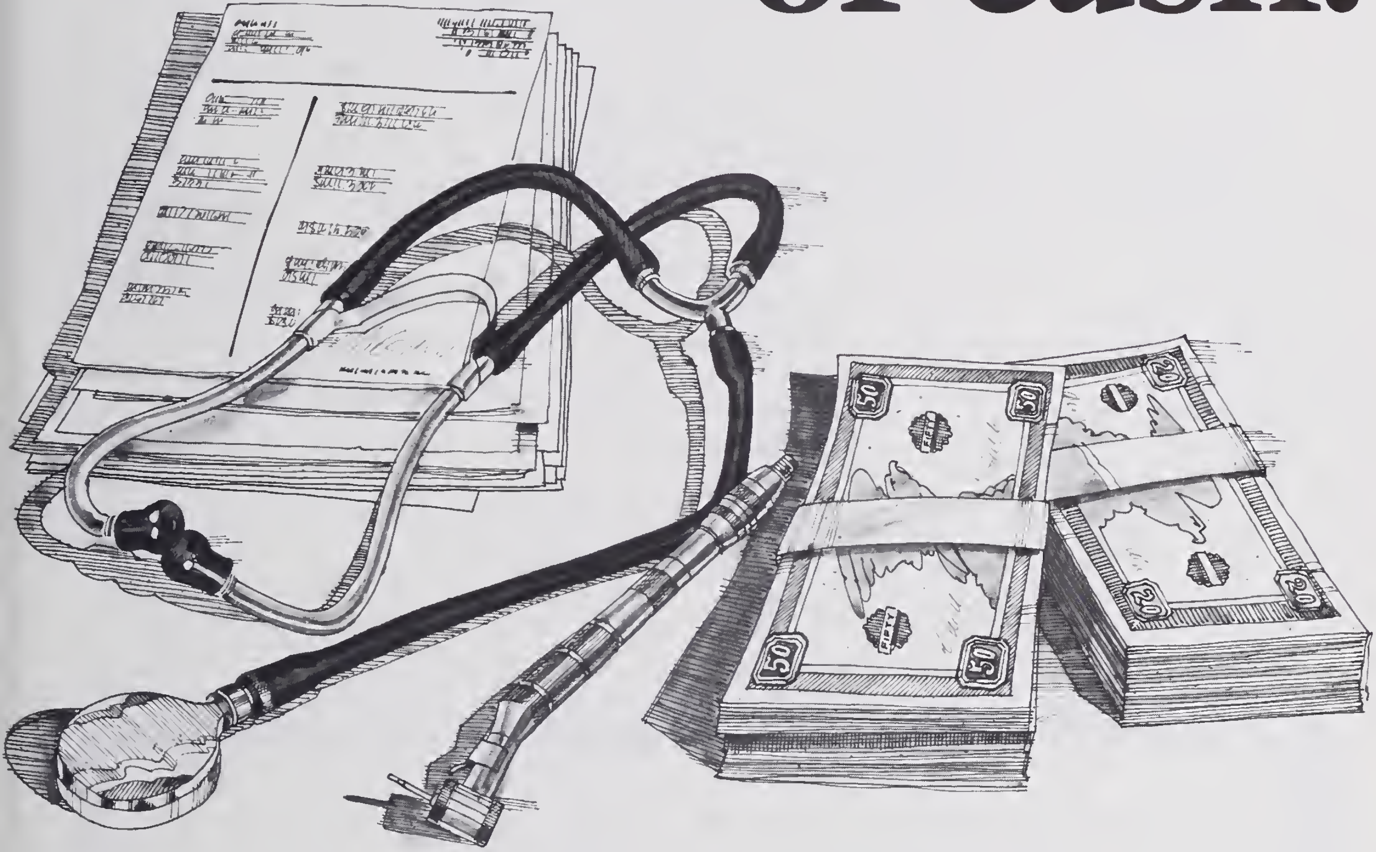

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POSITIONS AVAILABLE — With offices in Lansing, Oak Park and Traverse City, there are openings for physicians trained as Internists, Family Physicians or Psychiatrists — working with the Disability Determination Service under the Social Security Administration. Salary currently over $40,000 per year, plus 23% fringe benefits, including life, accident, long-term disability, hospital and major medical coverage. An outstanding benefit is deferred compensation. Pension benefits after 10 years' service. No weekends or nights. 50 hours allowed for obtaining necessary CME credits. Vacation leave and sick leave are given. Position entails review of medical records, training and teaching of disability examiners, as well as some community medical relations. An equal opportunity employer. All enquiries treated confidentially. For further details, please write: Disability Determination Service, Box 30011, Lansing, Michigan 48909, or call collect: Harry D. Nesmith, MD, Chief Medical Consultant, 517/373-7789.

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F.P.'s NEEDED — Growing community of 4000+ needs one or two MDs, two F.P.s in town and one nearby. Join existing practice or solo available. Excellent recreation and economy. Sixty miles from metro cities, 57 bed J.C.A.H. hospital in community. Trade area of 12,000+ U.S. grad preferred. Contact L. Wattier, Administrator, Memorial Hospital, Inc., 104 W. 17th, Schuyler, NE 68661, 402/352-2441.

Statement of ownership, management and circulation of Michigan Medicine

Statement required by the Act of October 23, 1962; Section 4369, Title 39 of the United States Code showing the Ownership, Management and Circulation of Michigan Medicine, published three times per month, 36 issues, mailed at East Lansing, Michigan, and additional post offices in Ingham County for December 1, 1977.

1. The office of the publisher is located at 120 West Saginaw Street, East Lansing, Michigan 48823.

2. The general business office of the publisher is located at 120 West Saginaw Street, East Lansing, Michigan 48823.

3. The publisher is the Michigan State Medical Society. The managing editor is Judith Marr, 120 West Saginaw Street, East Lansing, Michigan 48823; the executive editor is Herbert A. Auer, 120 West Saginaw Street, East Lansing, Michigan 48823.

4. The owner is the Michigan State Medical Society, 120 West Saginaw Street, East Lansing, Michigan 48823.

5. The known bondholders, mortgagees and other holders owning or holding 1 percent or more of total amount of bonds, mortgages, or other securities are: None.

6. A. The total number of copies printed averages 8,761 per issue with a single issue nearest to filing date accounting for 8,840 copies.
   B. Paid circulation 8,105 subscriptions by mail, these being the active members of the Michigan State Medical Society, and others who receive subscriptions.
   C. Sales to dealers, number none.
   D. Free distribution by mail carrier or other means: 321
   E. Total number of copies distributed is 8,761.

I certify that the statements made by me above are correct and complete.

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Potpourri

By Herbert A. Auer, Executive Editor

Between 1968 and 1975, the overall death rate in the USA dropped by almost 14 percent. From 1960 to 1975, infant deaths dropped 38 percent from 26 to 16 infant deaths per 1,000 live births, the lowest ever recorded during the 15-year period.

* * *

"In America, we have improved the availability of physician services and largely eliminated the gap between visits made by rich and poor, or white and black, and we have greatly expanded the number of health professionals who provide this medical care," declare David E. Rogers, MD, and Robert J. Blendon, ScD, in a recent report of the Robert Wood Johnson Foundation.

* * *

The first major private hospital to be built in the United Kingdom since 1974 was recently dedicated by Princess Grace of Monaco. The Princess Grace Hospital was named to recognize her charitable activities throughout Europe and especially in behalf of children.

* * *

Physicians more and more are speaking out about the importance of good nutrition. Recently Richard E. Palmer, MD, immediate past president of the AMA, said in Chicago, "Americans eat too much and we eat the wrong kinds of food. We sometimes drink too much. Yes, we are healthy, but not as healthy as we ought to be."

* * *

Writing in *Medical Economics,* Richard C. Bates, MD, of Lansing, says, "almost nothing in medicine gets done without a doctor's willing it; but — more important to cost cutting endeavors — almost nothing can be denied a physician who demands care for his patient."

* * *

Victor R. Fuchs, professor of economics at Stanford, reports that of every $100 spent for health in the United States, only about $20 goes for physicians' services compared to more than $40 for hospital care and another $10 for drugs.

* * *

Who is quoted more than Benjamin Disraeli, the great man who lived from 1804 to 1881? He wrote: "To be conscious that you are ignorant of the facts is a great step to knowledge."

* * *

Edward S. Maxim, MD, Macomb County Medical Society president, urges physicians "to participate in all levels of organized medicine, including membership in the AMA. With all the problems that the medical profession faces in its efforts to continue to deliver quality medical care without undue outside pressures and restrictions, this can only be accomplished through organizations like the Macomb County Medical Society, and its state and national counterparts."

* * *

Were you aware that . . . HEW did not release the names of 315 of its employes who recently were discovered to have defaulted on federal loans they received to help finance their education. These 316 HEW employes owe the government $403,000. They received a soft letter pleading with them to pay up.

* * *

The AMA reported results of a recent survey by HEW which found the typical physician worked 58 hours each week in 1975. According to the Commerce Department's "Statistical Abstract of the U.S.," the average American work week is 36.1 hours. The AMA found that converting the physician's average net income of $53,600 to that of a 36.1 hour work week brought the figure down to $33,400 — before deducting the "fringe benefits" most persons receive from their employers.

* * *

It was David Hume, a great British philosopher, who once said, "Freedom is seldom lost all at once, but rather in small degrees."

* * *

Announcing a new auto leasing program exclusively designed for MSMS members

MSMS has made arrangements with McCullagh Leasing, Inc., one of the nation's foremost leasing organizations, to provide members with a special, low cost auto leasing program. You will receive the same attractive monthly rates on your single car that large fleet operators get on bulk leases.

Benefits of the Program

Financial

- No down payment.
- Frees capital for personal or business use.
- If auto is used for business, you may enjoy tax advantages.
- Preferential monthly lease payments.
- The equity you have in your present auto can be applied to other productive uses.

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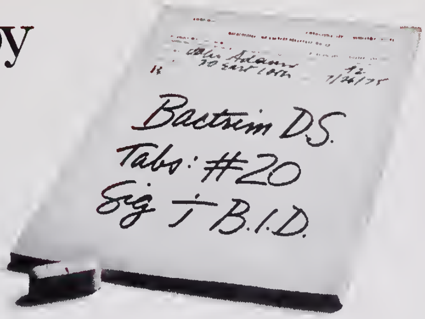
- Eliminates shopping around for the best price and bargaining over trade-ins.
- Complete freedom from time-consuming licensing and registration paperwork. We handle it all.
- Your auto is personally delivered directly to either your home or office at a prearranged time already licensed, serviced and washed.
- Exclusive "Man-In-Detroit" Warranty back-up service to resolve local service problems.
- Monthly statements simplify your tax records.
- Tailor your car to fit your life style or the image you want to project. Broad selection of make, model, trim, upholstery colors and optional equipment.

Automotive Services and Tires Program

- Generally, substantial savings on the purchase of tires, batteries and other automotive services.
- McCullagh Purchase Card covers services available through over 100,000 supply points of Sears, Goodyear, General Tire, B. F. Goodrich, Firestone, Uniroyal and Montgomery Ward company stores.
- McCullagh Leasing, Inc. invoices you for each purchase you make with a McCullagh Charge Card and substantiates it by attaching a copy of the signed invoice.

10-day Bactrim therapy outperforms 10-day ampicillin therapy.



In a multicenter, double-blind study of patients with chronic or frequently recurrent urinary tract infection, Bactrim 10-day therapy outperformed ampicillin 10-day therapy by 27.2%, when comparing patients who maintained clear cultures for eight weeks. Criterion for "clear culture" was 1000 or fewer organisms/ml of urine.

While adverse reactions noted in this study were mild (*e.g.*, vomiting, nausea, rash), more serious reactions can occur with these drugs. See manufacturer's product information for complete listing. Maintain adequate fluid intake; perform frequent CBC's and urinalyses with microscopic examination.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

Double Strength tablets Just 1 tablet B.I.D.

Bactrim™

(80 mg trimethoprim and 400 mg sulfamethoxazole)

2 tablets B.I.D.

For chronic or frequently recurrent cystitis and pyelonephritis due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections evidenced by persistent bacteriuria (symptomatic or asymptomatic), frequently recurrent infections (relapse or reinfection), or infections associated with urinary tract complications, such as obstruction. Primarily for cystitis, pyelonephritis or pyelitis due to susceptible strains of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris* and *Proteus morganii.*

NOTE: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections. The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; fruit-licorice flavored — bottles of 16 oz (1 pint).

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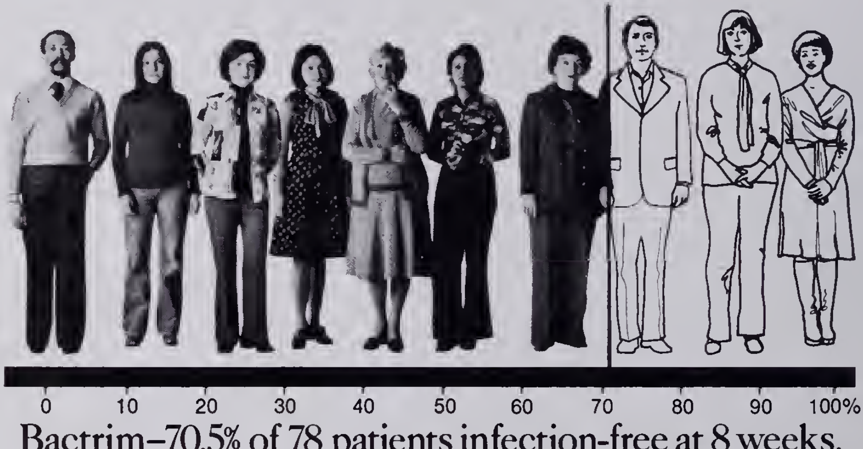
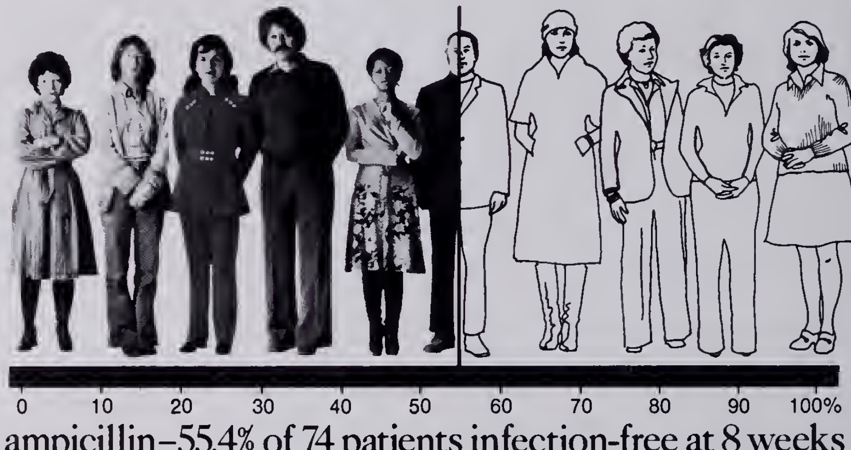
In a multicenter study of patients with chro infections

Bactrim was 27.2%* more effective than ampicillin in keeping patients infection-free for 8 weeks.†



Bactrim–70.5% of 78 patients infection-free at 8 weeks.



ampicillin–55.4% of 74 patients infection-free at 8 weeks.

*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

†Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110

Bactrim™ DS
(160 mg trimethoprim and 800 mg sulfamethoxazole)

Double Strength tablets
Just 1 tablet B.I.D.

Please see summary of product information on preceding page. ROCHE

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

Official Journal of the Michigan State Medical Society
Volume 76, Number 35 • December, 1977

Michigan Medicine

Significance of Blues programs as key Michigan MDs see them

Good, practical suggestions for minimizing risk

Also inside:

Profile of Dennis Cawthorne

MSMS car leasing program

Peer review reviewed

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A character all its own.

Valium (diazepam) is a benzodiazepine with a character all its own. Pharmacologically, it has been described as more potent mg-per-mg than other available anxiolytic benzodiazepines. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium® (diazepam) ⓘⓥ

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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THE ANXIETY-SPECIFIC.

- a predictable pattern of patient response
- seldom associated with serious side effects, in proper dosage
- rarely interferes with mental acuity
- used concomitantly with many primary medications
- three dosage strengths meet most patient needs

LIBRIUM® ©IV

chlordiazepoxide HCl/Roche

5 mg, 10 mg, 25 mg capsules

Libritabs® (chlordiazepoxide) available in 5 mg, 10 mg and 25 mg tablets.

LIBRIUM® 5 ROCHE
LIBRIUM® 25 ROCHE
LIBRIUM® 10 ROCHE

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.;* severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules,* 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets,* 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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THE ANXIETY-SPECIFIC.

Since its discovery in the research laboratories at Roche, Librium has been the object of ongoing pharmacologic and clinical investigation.

The published record on Librium is enormous. So large, in fact, we put it into a computer literature retrieval system to make it more accessible in answering your inquiries.*

It's a record that reveals a consistent pattern of patient response. A highly favorable benefits-to-risk ratio. And minimal interference with many primary medications.

Doing one thing well. Basically, that's what Librium is all about.

LIBRIUM® ⒸIV
chlordiazepoxide HCl/Roche

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Please see preceding page for a summary of product information.

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